Missouri

UNIFORM APPLICATION
FY 2009

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Missouri
DUNS Number: 780871430-

Uniform Application for FY 2009 Substance Abuse Prevention and Treatment Block Grant

I. State Agency to be the Grantee for the Block Grant:

Agency Name:	Missouri Department of Mental Health	
Organizational Unit:	Division of Alcohol and Drug Abuse	
Mailing Address:	1706 E. Elm Street P.O. Box 687	
City:	Jefferson City	Zip Code: 65102-0687

II. Contact Person for the Grantee of the Block Grant:

Name:	Mark Stringer	
Agency Name:	Missouri Department of Mental Health Div. of Alcohol and Drug Abuse	
Mailing Address:	1706 E. Elm Street P.O. Box 687	
City:	Jefferson City	Zip Code: 65102-0687
Telephone:	(573) 751-9499	FAX: (573) 751-7814
Email Address:	mark.stringer@dmh.mo.gov	

III. State Expenditure Period:

From: 7/1/2006 To: 6/30/2007

IV. Date Submitted:

Date: 9/30/2008 8:18:51 AM Original: ◉ Revision: ○

V. Contact Person Responsible for Application Submission:

Name:	Mark Stringer	Telephone:	(573) 751-9499
Email Address:	mark.stringer@dmh.mo.gov	FAX:	(573) 751-7814

Form 2 (Table of Contents)

State: Missouri

FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act

Title XIX of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications

As required by Title XIX of the PHS Act (continued)

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Missouri

Name of Chief Executive Officer or Designee: Mark Stringer

Signature of CEO or Designee:

Title: Division Director **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Division Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐
a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐
a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐
a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Division Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

State: Missouri

FY 2006 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2006 is reflected on line 8 of the Notice of Block Grant Award.

$26,062,300

Missouri

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

During FY 2006, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state based on needs assessments and the availability of qualified care providers. Treatment and support services were delivered via 38 Primary Recovery contracts and 50 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts, which includes three opioid treatment providers. There were 101 providers of recovery support services.

Detoxification

Often the first step in recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of detoxification programs available in Missouri are modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's Purchase of Service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment, individual and group counseling, group education, community support, residential or housing support as appropriate, trauma individual and group counseling, and family therapy. In addition, families can also participate in individual and group codependency counseling.

In FY 2006, there were four different types of CSTAR programs available in Missouri: women and children, adolescent, general population, and opioid. All offer three graduated levels of care. The most intensive level offers a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women and Children's Treatment Programs

Substance abuse can affect women differently than men, both physically and psychologically. Specialized CSTAR programs are offered for women and their children with programming that is relevant to this population. Pregnant women and women with children in their care are the priority populations. The full array of services is available and is tailored to the consumer's unique needs. In addition, daycare is provided to

ensure childcare is not an obstacle to treatment. Alternative Care (Alt Care) is a more specialized type of women and children's program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Alt Care is designed specifically for female offenders being released from correctional institutions and those under probationary supervision. There is one program in each of Missouri's two metro areas, St Louis and Kansas City.

CSTAR Adolescent Programs
Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in residential settings are offered academic support services to minimize disruptions in their education.

CSTAR General Population Programs
CSTAR General Population programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

CSTAR Opioid Programs
Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines. By the end of FY 2006, the three ADA contracted opioid programs were converted to the CSTAR model.

Primary Recovery and Primary Recovery Plus (PR+)
Missouri's primary recovery programs offer a full continuum services within multiple levels of care, modeled after the CSTAR program. Detoxification services are available to any Missourian in need, but are accessed through the PR+ providers. Three of the providers offer modified medical detoxification services versus social setting detoxification. All primary recovery programs were converted to the Primary Recovery Plus (PR+) model in FY 2006 under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which are on file with the Missouri Secretary of State.

FY 2008 (Progress)

In FY 2008, the Division of Alcohol and Drug Abuse (ADA) continued to support and monitor a full continuum of substance abuse treatment services throughout the state of Missouri via contracts with private treatment providers. Treatment and support services were delivered via 38 Primary Recovery Plus contracts and 35 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts. The decrease in the number of CSTAR contracts between FY 2006 and FY 2008 simply reflects a change in how contracts were drafted; there was no decrease in the number of available programs.

All primary recovery programs were converted to the Primary Recovery Plus (PR+) model in FY 2006 under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity. Recovery supports were intended to help keep consumers engaged in treatment for longer periods of time by addressing issues that may otherwise serve as barriers to treatment completion. As of June 30 2008, there were 74 contracted recovery support providers. An expanded menu of recovery support services is available which includes re-entry coordination, care coordination, work preparation and pastoral counseling. Missouri was awarded a second ATR grant, which was largely implemented in FY 2008. This award allowed for the continuation of the program objectives, with an increased emphasis on the treatment of methamphetamine dependent consumers.

Both the CSTAR programs and the PR+ programs continue to provide a multi-level system of care with a wide service menu that can be applied to meet consumers' individual needs. All services previously cited were continued in FY 2008. New services were added this fiscal year to enhance the quality of care and promote provider utilization of evidence-based practices. Services added to all provider contracts include the following: Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, APN, or psychiatrist), Extended Day Treatment, and the Clinical Supervision of Counselors. The Clinical Utilization Review Unit continues to function as a monitoring, consulting, and training unit within ADA to ensure the best consumer care is provided in an appropriate, efficient manner.

FY 2008 marks the second year of the partnership established between ADA and ten contracted substance abuse treatment providers located throughout Missouri through the support of the Robert Wood Johnson Foundation grant. The purpose of the grant is to study processes and practices within the state and provider systems that are barriers to the use of evidence-based practices (EBP), and consequently improve those practices to increase the utilization of EBP. The focus of the first project year was the development and implementation of medication-assisted services to treat alcohol dependence. Efforts to achieve this goal in FY 2008 included the amending of provider partner contracts to allow for the reimbursement of medication, physician, and

laboratory services associated with the use of naltrexone or acamprosate. The focus in the second year is increased utilization of motivational interviewing. Walk-through exercises were conducted at the provider and state levels during the implementation planning stage.

The Division of ADA continues to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls include: current issues in opioid treatment; disaster planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to fund the established continuum of services described in the above sections, but will promote and support a wider utilization of evidenced-based practices by treatment providers.

In early FY 2007, ADA entered into a partnership with ten contracted substance abuse treatment providers located throughout Missouri through the support of the Robert Wood Johnson Foundation two year grant. The purpose of the grant is to study processes and practices within the state and provider systems that are barriers to the use of evidence-based practices (EBP), and consequently improve those practices to increase the utilization of EBP. The focus of the first project year was the development and implementation of medication-assisted services to treat alcohol dependence. The focus in this coming year is increased utilization of motivational interviewing. Of particular interest is the use of this technique prior to or at the time of the initial assessment to promote consumer engagement earlier in the treatment process, when disengagement is common. Changes have been made to a small number of provider contracts to allow billing for a brief motivational intervention prior to the completion of the comprehensive assessment. Utilization and outcomes will be monitored with the expectation that this service option will be expanded to more providers in the coming year.

In an effort to enhance the quality of care and promote provider utilization of evidence-based practices, additional services were added to the service menu in FY 2008 to include: Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, APN, or psychiatrist), Extended Day Treatment, and the Clinical Supervision of Counselors. In FY 2009, particular attention will be paid to the implementation of Vivitrol, the injectible form of naltrexone, for the use of severe alcohol addiction. Research has shown that this form of the medication can be especially useful for individuals at high-risk for relapse and for whom daily medication administration is an obstacle to recovery. The Department of Corrections (DOC) is also very interested in the use of this medication with its population in the hopes of reducing relapse, recidivism and revocation of probation/parole. As there is a very high incidence of shared consumers by ADA and the DOC, the two departments are partnering to develop a protocol that includes the use of Vivitrol.

The Division of Alcohol and Drug Abuse administers funding and oversees all community-based substance abuse treatment services for offenders. A Memorandum of Understanding with the Department of Corrections delineates the terms of this collaborative working relationship. The community-based programs for offenders that are currently managed by ADA include outpatient services, Alt Care and Free and Clean programs in St. Louis and Kansas City, and a Partnership for Community Restoration program in St. Louis.

ADA continues to pursue the establishment of Centers of Excellence for the comprehensive treatment and prevention of substance abuse disorders and compulsive

gambling. In doing so, providers will embody the “13 Principles of Effective Treatment” developed by the National Institute on Drug Abuse. Prevention providers and coalitions will employ the Strategic Prevention Framework.

In order to move forward with this initiative, ADA has asked the State Advisory Council (SAC) to define and make recommendations for the development of Centers of Excellence. The SAC is comprised of many stakeholders to include the following: consumers, providers, Missouri Recovery Network, ACT Missouri, Missouri Institute of Mental Health, Committed Caring Faith Communities, and partnering state agencies. Work groups will also be formed to focus on specific areas such as services for adolescents, women, offenders and senior adults.

The Division of ADA will continue to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls will include: current issues in opioid treatment; disaster planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

Missouri
Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

• ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

o ***Universal Direct. Row 1***—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

• ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

• ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

FY 2006 (Compliance)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) supported 11 Regional Support Centers in providing information on legislative updates, team leader meetings, grant and funding information, and conference and workshop information to over 200 community coalitions consisting of over 2,000 members. ADA's Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis provided current prevention information to prevention practitioners at the state and community levels. ADA's RADAR network targeted people who were ages 5-64, potentially reaching 4.4 million people. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network supported local communities by providing information to the coalitions about preventing teen alcohol, tobacco, and drug use.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, published a newsletter titled "Journeys". The newsletter was published quarterly and provides education and prevention messages to encourage the reduction in underage and binge drinking. "Journeys" was distributed to over 200 people across the state affiliated with colleges and universities, local agencies, and community teams. PIP continues to support a website to disseminate substance abuse information to the public. Risk and Protective factors are utilized and examples of focus topics included alcohol, marijuana, underage drinking, suicide, and Fetal Alcohol Spectrum (FAS) Disorder.

Education

Merchant education materials were developed annually and distributed to the Regional Support Centers (RSC) for dissemination during the annual tobacco merchant education campaign. The merchant education campaign included a phone call and two walk-in visits to the state's roughly 6,500 tobacco retail outlets. During the campaign, the RSCs informed the merchants of the availability of additional technical assistance and employee training. Several support centers have partnered with the Division of Alcohol and Tobacco Control and have provided training to vendors in their region.

ADA's 11 RSCs conducted statewide merchant education visits between the months of March and May 2006. The purpose of these visits was to provide information and education regarding the state's law on youth access to tobacco products. Each retailer received two walk-in visits. More than 20,000 phone and walk-in contacts were completed.

The Missouri School-based Prevention and Intervention Initiative (SPIRIT) program implemented evidence-based curriculum which included Peace Builders, Positive Action for Living, Second Step, Too Good for Drugs, Life Skills Training, Project Towards No Drug Abuse, and Reconnecting Youth in five sites located in Kansas City, Knox County,

St. Louis, Carthage, and New Madrid. The SPIRIT program served 5217 students during FY 2006.

ADA partnered with the Department of Health and Senior Services (DHSS) in the FAS prevention grant solely funded by the Centers for Disease Control and Prevention. The grant's target area was identified as approximately two-thirds of the state, excluding the metropolitan areas of Kansas City and St. Louis. Seventy-one of the 115 counties comprise this area. Data from the 2000 census and DHSS indicate that this geographic area has at least 500,000 childbearing-age women between the ages of 12 and 44. FY 2006 was year three of the grant award.

Mobilization

The RSCs responded to the technical assistance needs of over 200 local teams, task forces and coalitions in developing the skills necessary for effective functioning. The support centers utilized a community assessment tool to survey their community coalitions in their service areas. This tool helped the teams to identify target areas, focus their work efforts, and enhance their community effectiveness. Services to diverse target populations were supported with technical assistance to enhance their capacity to support youth-based and culturally specific community groups such as deaf, Native American, and Hispanic coalitions.

The Missouri School-based Prevention and Intervention Initiative (SPIRIT) program provided contracted training for staff from the five participant sites to encourage their implementation of evidence-based curriculum which included Peace Builders, Positive Action for Living, Second Step, Too Good for Drugs, Life Skills Training, Project Towards No Drug Abuse, and Reconnecting Youth. Seven trainings were provided throughout the state to accommodate the five SPIRIT sites. Trainings were held in Jefferson City, Kansas City, Knox County, and St. Louis during 2006.

In FY 2006, a consultant bank provided training and technical assistance in specific areas to 82 teams to develop alternative activities and program development. Another resource for communities was provided through mini-grants. There were 62 awards ranging from $1,500 to $10,000 distributed under the categories of capacity building, sustainability, and social norms/environmental change. The average award was $6,700. ADA utilized the U.S. Education Office of Safe and Drug Free Schools Governor's Discretionary funds for the mini-grants and consultant bank resources provided to community coalitions.

Partners in Prevention (PIP) is a statewide coalition comprised of 12 Missouri universities across the state whose goal is to develop strategies for reducing and preventing high-risk drinking among Missouri's college students through partnerships with universities and local coalitions. Partners in Prevention (PIP) provided on-going training to 1,012 higher education professionals and college students through a statewide conference and monthly meetings during FY 2006.

Under the direction of ADA, the Prevention Workforce Development Task Force continued studying Missouri's workforce. One of the key findings from a Workforce Survey administered by the Task Force was that prevention in Missouri needed to be professionalized. ADA utilized this review to identify the requirements for certified prevention professionals. The review resulted in identifying the topics for various education opportunities offered to train prevention professionals for certification. The Task Force continued to outline prevention domains specific to the needs of Missouri's prevention professionals. In FY2006, the Task Force consulted with the Missouri Substance Abuse Counselors Certification Board (MSACCB) for recommendations regarding Missouri's Prevention Credentialing.

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 17-20, 2006 with 880 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care, evidence-based prevention, cultural and linguistic competence, criminal justice, ethics, treatment planning for successful community outcomes, effective models for prevention in the treatment setting, and others.

The Division of ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The focus of the training included community assessments, capacity building, and measurable outcomes. ADA consistently collaborated with the Center for Substance Abuse Prevention (CSAP)'s Southwest Center for the Application of Prevention Technology to provide training and technical assistance to promote community development, accountability, and targeted prevention initiatives based on CSAP's best practice program recommendations. ADA supported the 19th annual National Prevention Network Prevention Research Conference held August 2006 in Kentucky.

Alternatives

ADA's 11 Regional Support Centers and 1 Statewide Training and Resource Center provided training and technical assistance to approximately 200 community coalitions to support local activities which promoted healthy alternatives to alcohol, tobacco, and other drug use. The training and technical assistance to the community coalitions resulted in community coalitions providing alternative prevention activities to approximately 3,000 participants throughout the year as identified by their annual community team action plans. Activities provided by the community coalitions were local health fairs, alcohol, tobacco, and other drug free community and social/recreational events.

Alternative prevention activities such as community service and youth leadership projects, such as peer education groups, were provided to approximately 2,000 college aged students at the 12 Missouri universities comprising the statewide PIP coalition.

Environmental (Social Policy)

Partners in Prevention (PIP) encourages and nurtures collaboration among colleges and state agencies to develop strategies for reducing and preventing high-risk drinking among Missouri's college students and to create partnerships that will result in systemic environmental change. During FY 2006, PIP worked with each of the 12 campus coalitions, comprising the PIP Coalition, to help them change their campus policies to make sure they were reflective of the new alcohol laws (minor in possession by consumption, open house party regulation laws) and made sure the 30,000 students understood the new policies.

Problem Identification and Referral

In the spring of 2006, the 12 PIP universities conducted the Core Institute Alcohol and Drug Survey. The survey was administered to a random sample of 5% of the student population reaching a total of 6,669 students. According to the 2006 Core survey results, 58.9% of the Missouri college students reported using alcohol before age 18, and 25.6% of students reported regular use of alcohol in the past year. Survey results also indicated that 48.4% of students had engaged in binge drinking at least once in the past two weeks. In terms of problems with the law, the survey showed that 11% of the students had been in trouble with the police due to alcohol or drugs. An additional question was added to the Core survey, "How many times in the past two weeks have you had five or more drinks in a **two-hour period**?" Student response indicated that 39.6% did engage in this behavior at least once. This behavior will continue to be surveyed.

Children accompanying their mothers into specialized Women and Children Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs were provided age-appropriate, developmentally-based support services for children to break the cycle of inter-generation substance abuse. All contracted CSTAR treatment programs provided specialized services to women and their children to address therapeutic issues relevant to the children. Services were provided by qualified child development professionals who were knowledgeable about substance abuse prevention. Screenings were conducted for each child under age 12 whose mother was admitted for residential treatment for substance abuse. The mother's treatment record included documentation of their child's developmental, physical, emotional, social, educational, and family background and current status. When indicated with the screening, a qualified staff member completed an assessment to identify appropriate therapeutic services. The age-appropriate activities offered included training and guidance in building self-esteem; learning to identify and express feelings; building positive family relationships; developing decision making skills; understanding chemical dependency and its effects on the family; learning to practice nonviolent ways to resolve conflict; and learning safety practices to reduce sexual abuse. These activities were provided to enhance the social and family functioning and to increase resiliency.

FY 2008 (Progress)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) information dissemination strategy was implemented through multiple prevention providers including the three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Training and Resource Center, the University of Missouri sites, and community coalitions. Information was disseminated using broadcast media and potentially reached four million individuals aged 5 to 64 years. ADA continued to support resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events where information on alcohol, tobacco, and other drug (ATOD) use and abuse was disseminated to community members. National prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month also provided opportunities for RSCs and community coalitions to disseminate information about ATOD to community members. Support Center staff continued to make presentations to area civic groups at the local community levels. The 164 community coalitions served as an ongoing venue to distribute information at the local level throughout the state. Information distributed included ADA fact sheets on alcohol, underage drinking, marijuana, women and alcohol, and methamphetamine.

The Division of ADA's Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis continued to provide current information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network continued to support local communities by providing information to the coalitions about preventing teen ATOD use and interventions for high risk groups. Several RSC's published newsletters and produced websites that provided information to their community coalitions about capacity building and important facts about ATOD. They also showcased success stories which helped motivate communities with similar circumstances and problems.

The Division of ADA continued to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education. The Division of ADA collaborated with the Missouri Division of Highway Safety to fund the PIPSMART & Cheers programs. The PIP continued to develop strategies for reducing and preventing high-risk drinking and its negative consequences among Missouri's college students. PIP encourages and nurtures collaboration among colleges and state agencies to develop strategies for reducing and preventing high-risk drinking and its negative consequences among Missouri's college students and to create partnerships that will result in systemic environmental change. Partners in Prevention (PIP) sent out a bi-annual informational newsletter to over 200 people affiliated with colleges and universities, local agencies, and community teams. A new website for suicide was developed with a link on the PIP website. Gambling information continued to be featured on the PIP website.

Education

The Center for Substance Abuse Prevention (CSAP) Model Programs continued to be implemented through community-based contracts with Boys and Girls Clubs at 14 locations, faith-based sites in Kansas City, and community sites in southwest and central Missouri. The curricula and their intended audiences are: Creating Lasting Connections (children 8-12 and their parents/guardians); All Stars (children aged 11-14 years); and Smart Moves (children aged 8-17 years). The curricula were provided to 61,744 youth.

CSAP Model Programs were also implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five schools. The programs included Peace Builders, Reconnecting Youth, Second Step, 2 Good For Drugs, Project Towards No Drug Abuse, and Life-Skills. An estimated 6,588 students were served through the SPIRIT program.

Merchant education materials were developed yearly and distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. During the campaign the RSC's informed retailers of the availability of technical assistance and training for their employees. The merchant education campaign consisted of a phone call and two walk-in visits to the retailers. Several support centers have partnered with the Division of Alcohol & Tobacco Control and have provided training to vendors in their region.

Mobilization

The Regional Support Centers provided education to approximately 164 community coalitions on coalition building, sustainability, grant writing, alcohol and drug abuse prevention, and evidence-based strategies.

There were approximately 164 community coalitions registered with ADA. Sustainability and capacity building continued as the focus of the 11 RSCs that provided technical assistance to the coalitions. The RSC technical assistance continued to include a community assessment that addressed strategic thinking, broad diverse community membership, coalition leadership, diversified funding sources, training, and evaluation. The RSCs continued to work with local coalitions to prioritize their goals based on the outcomes of this assessment. Local teams continued to be encouraged to work with other prevention-related teams and task forces.

The statewide coalition PIP comprised of 12 Missouri universities continued to develop strategies for reducing and preventing high-risk drinking and its negative consequences among Missouri's college students. Partners in Prevention (PIP) continued to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and

other drug abuse among Missouri college students through monthly meetings, a state-wide conference, and one-day workshops/trainings. An estimated 1,200 participated in training activities offered through the PIP program. Through Strategic Prevention Framework State Incentive Grant (SPF SIG) funds more judicial and law enforcement officers and professionals and University staff/students were sent to out-of-state conferences for training.

ADA utilized the U.S. Education Office of Safe and Drug Free Schools Governor's Discretionary funds for the technical support provided by the consultant bank. The consultant bank provided training, program development, and technical assistance to teams related to specific problem areas. Over 86 consultant bank requests were approved. Approximately 860 people were served through the requests.

Alternatives

Community coalitions and community-based providers continued to offer alternative prevention activities throughout the year. Local team action plans identified alternative activities to implement drug-free community events, adult-led youth groups, coaching activities, tutoring programs, and youth mentoring programs to approximately 4400 participants.

Alternative prevention activities were continued through PIP. The PIP statewide coalition comprised of 12 Missouri public institutions for higher education provided community service activities and peer education leadership functions as alternative prevention activities. An additional 500 drug-free alternative activities and events were conducted on all campuses collectively.

Environmental (Social Policy)

The RSC's provided training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members received education regarding alcohol and substance abuse as part of their orientation. Information on social policy issues was provided to teams via the "ACTION" newsletter of ACT Missouri. The network of community coalitions were involved at the local district levels and at the state level by testifying before legislative committees. Community team members were involved in legislation related to the ban of Alcohol Vaporizers, Banning anyone under 21 from Bars and Nightclubs, special fund for Reduction of Alcohol-Related programs and underage drinking, and Ban of Alcohol in the Capitol and on Capitol grounds. Community teams also acted as change agents by educating teens about alcohol use and developing strategies for changing laws and policies related to alcohol in conjunction with Missouri's Youth/Adult Alliance.

The Division of ADA continued to support PIP, the coalition comprised of representatives from 12 public universities. One of PIP's goals was to reduce binge and risky drinking and its negative consequences among Missouri's college students. An

estimated 6,000 students were reached through PIP in FY 2008. In FY 2008 more schools participated in social norming campaigns than ever before. While social norming remains a focus of the 12 PIP schools it is part of a synergistic approach made up of 4 different strategies: 1) Educational, 2) Environmental management, 3) Social norming, and 4) Health promotion. Community Trials, an evidenced-based program, was implemented in FY 2008 at all 12 Universities. Each site has a coalition and judicial officers to uphold policy. Some officers have reported changing their code of conduct in relation to PIP issues due to the training and education.

The Division of ADA continued to collaborate with the Department of Health and Senior Services (DHSS) to reduce the rate of alcohol-exposed births, to effect proactive changes in public policy impacting alcohol use during pregnancy, and to enhance service coordination and delivery to this identified high-risk target population. This was the last year for this grant.

Problem Identification and Referral

The Division of ADA continued to identify and respond to substance abuse-related problems of young children of women who were receiving treatment for substance abuse in the contracted Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and their children. The focus on at-risk youth also continued with specifically modified prevention programming provided to deaf and hearing-impaired youth and adults through the operation of a “warm-line” which supports problem identification and effective referrals. In FY 2008 over 952 individuals were served through the “warm-line” service.

The Partners in Prevention campus based prevention coalition administered the Missouri College Student Health Behavior Survey (MCHBS) at the 12 publicly funded universities comprising the statewide PIP coalition. A total of 5,168 students were surveyed.

FY 2009 (Intended Use)

For FFY 2009, Missouri will continue to conduct the following activities to improve its outcome-based prevention infrastructure and service delivery, using the Center for Substance Abuse Prevention (CSAP) six strategies to report on the National Outcomes Measures (NOMS).

* Needs assessment using federal, State and local data
* Capacity development and mobilization at the local level for block grant and other prevention providers
* Planning and collaborating across State and community stakeholders to maximize resources
* Building capacity at the State level to support communities
* Evaluating for quality assurance and needed improvement

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) will continue to implement an information dissemination strategy through multiple prevention providers. This will include utilization of three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Resource Center, the participating members of the campus based Partners in Prevention (PIP), and the collaborative community coalition partners. ADA plans to support the resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events to disseminate information about alcohol, tobacco, and other drug (ATOD) use and abuse to community members. Other national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month will also continue to provide opportunities for RSCs and community coalitions to disseminate information about ATOD to their communities. The community coalitions consisting of over 2,000 members will continue to be an ongoing resource to provide information at the local level throughout the state.

The Division of ADA's RADAR network sites located in Jefferson City, Kansas City, and St. Louis will continue to make current prevention information available to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network will provide support to local communities by providing information to community coalitions and teams about preventing teen ATOD use and providing effective intervention strategies for high risk groups. Regional support center newsletter publications and prevention website maintenance will also continue.

The Division of ADA will continue to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition. In FY 2009 a new Missouri public institution of higher education will be joining the PIP statewide coalition. Therefore, the PIP statewide coalition will be comprised of 13 Missouri public institutions

of higher education. The PIP will continue to develop strategies for reducing and preventing high-risk drinking among Missouri's college students. The Division of ADA will continue to collaborate with the Missouri Division of Highway Safety to fund the PIPSMART and Cheers program. PIP will publish a quarterly newsletter titled "Journeys", which will be distributed to over 200 entities affiliated with at-risk youth. In collaboration with the Missouri Department of Elementary and Secondary Education, this newsletter and other informative materials for college-bound students may be electronically disseminated to every school system in Missouri. The prevention materials developed by PIP may be utilized by Missouri high-school counselors to encourage parents of college-bound students to prepare for the ATOD issues that their children will face during their college experience. These collaborative efforts will greatly increase the current distribution and dissemination of prevention materials across the state to those who may effectively utilize them with at-risk youth.

Education

The Division of ADA will continue to implement CSAP Model Programs through community-based contracts with Boys and Girls Clubs at 14 locations in Missouri. The curricula and their intended audiences are: Creating Lasting Connections, which is appropriate for children, ages 8-12 and encourages parent and guardian participation; All Stars, for children aged 11-14 years; and Smart Moves, for children aged 8-17 years. An estimated 61,744 youth aged 8-17 will be served with these age-appropriate curricula. In FY 2009 the Boys and Girls Clubs will be implementing the MethSMART program. This program will be provided to 360 kids and a minimum of 120 parents over the course of one year. This curriculum is for all age groups and parents. In addition all participants would stay involved in traditional Boys and Girls Clubs programs to further enforce healthy habits and positive life style. The MethSMART program funding is for one year only.

Center of Substance Abuse Prevention (CSAP) Model Programs will also be implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five school districts. The programs provide Peace Builders, Reconnecting Youth, Second Step, 2 Good For Drugs, Project Towards No Drug Abuse, and Life-Skills. ADA anticipates serving over 6,600 youth through the SPIRIT program. High school programs will continue to be implemented.

Merchant education materials will continue to be distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. The merchant education campaign will consist of a phone call and two walk-in visits to the retailers. During the campaign, RSCs will inform retailers of the availability of technical assistance and training for their employees.

Mobilization

The Regional Support Centers will continue to provide education to over 160 community coalitions on coalition building, sustainability, grant writing, alcohol and drug abuse prevention, and evidence-based strategies.

Ongoing support to the approximately 164 community coalitions registered with ADA will continue for FY 2009. Sustainability and capacity building will continue to be the focus of the 11 RSCs providing technical assistance to the community coalitions. Community assessment will address strategic thinking, diversity in community membership, coalition leadership, developing diversified funding sources, training, and outcomes evaluation. The RSCs will also continue to work with local coalitions to prioritize their goals as indicated by their community assessment outcomes. Local teams will be encouraged to work with other prevention-related teams and community task forces including Caring Community partnerships and Community Betterment and Development teams. This effort will be a collaborative effort with the Missouri Department of Economic Development.

The Division of ADA will continue to contract with the University of Missouri-Columbia to support the statewide PIP coalition comprised of 13 Missouri public institutions of higher education. The majority of public universities in PIP work with local community coalitions that function as an extension of PIP. Partners in Prevention (PIP) will continue to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and other drug abuse among Missouri college students through monthly meetings, a state-wide conference, and one day workshops/trainings. An estimated 1,200 will participate in training activities offered through the PIP program. For FY 2009 one of PIP's goals is to analyze the roles prosecutors play and plan trainings to educate them about PIP's goals and issues and the need for more consistent adjudication and prosecution related to these issues.

Alternatives

Alternative prevention activities will continue to be supported for community coalitions and community-based providers throughout the year with support from U.S. Education Office of Safe and Drug Free Community Governor's Discretionary funds. Resources to support alternative activities for approximately 4,000 participants will be included in the local team action plans and will be made available through resources provided by ADA. Examples of anticipated alternative prevention activities include after school and weekend alcohol, tobacco, and other drug-free social and recreational activities, community betterment projects, and mentoring programs for at-risk youth.

The statewide PIP coalition comprised of 13 Missouri public institutions of higher education will continue to offer alternative activities to an anticipated 500 participants through community service activities and peer education leadership functions.

Environmental (Social Policy)

The RSCs will provide training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members will receive training regarding ATOD issues. Information concerning social policy issues will be provided to teams through the "ACTION" newsletter published by ACT Missouri. The network of community coalitions will continue their involvement at the local district levels and at the state level to support legislative initiatives which encourage prevention efforts that reduce youth risk. ADA anticipates the continued involvement of community team members in legislation related to the ban of Alcohol Vaporizers, banning anyone under 21 from Bars and Nightclubs, Special fund for Reduction of Alcohol-Related Problems and Underage Drinking, and Ban of Alcohol in the Capitol and on Capitol grounds. ADA anticipates that the community teams will continue to act as change agents by educating teens about alcohol use and developing strategies for changing laws related to alcohol.

The Division of ADA will continue to support PIP, the coalition comprised of representatives from 13 publicly funded universities. PIP's goal is to reduce binge and risky drinking and its negative consequences among Missouri college students. An estimated 6,500 students will be reached through PIP in FY 2009. Social-norming campaigns will continue to be a priority for the participating college campuses and reach 130,000 students statewide. Student Alcohol Responsibility Training (START) will begin in September FY 2009. There will be an increased emphasis on DWI training to improve adjudication, arrests and prosecution and more education among law enforcement, communities and judicial professionals. PIP will continue to focus on all four of their strategies. Community Trials will continue to be implemented in FY 2009.

Problem Identification and Referral

The Division of ADA will continue to identify and respond to the substance abuse related problems of young children of women who are participating in substance abuse treatment at the contracted Comprehensive Substance Treatment and Rehabilitation sites. ADA will continue to support prevention services which respond to the needs of youth and the deaf and hearing impaired populations. ADA anticipates that 1,000 individuals will be served through the "warm-line" system that provides problem identification and referral for these populations.

Partners in Prevention (PIP) will continue to administer the Missouri College Student Health Behavior Survey at the 13 publicly funded universities comprising the coalition. An estimated 5,400 college students will be surveyed across the state.

State: Missouri

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

(●) Yes ( ) No ( ) Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

( ) Yes (●) No ( ) Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
( ) Yes	( ) Yes	( ) Yes
(●) No	(●) No	(●) No
( ) Unknown	( ) Unknown	( ) Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

( ) Yes (●) No ( ) Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	(●) Yes	( ) No	( ) Unknown
Dissemination of materials?	(●) Yes	( ) No	( ) Unknown
Media campaigns?	(●) Yes	( ) No	( ) Unknown
Product pricing strategies?	(●) Yes	( ) No	( ) Unknown
Policy to limit access?	(●) Yes	( ) No	( ) Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

(●) Yes ( ) No ( ) Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as:

(HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○ Yes ◉ No ○ Unknown
New product pricing:	○ Yes ◉ No ○ Unknown
New taxes on alcoholic beverages:	○ Yes ◉ No ○ Unknown
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○ Yes ◉ No ○ Unknown
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○ Yes ◉ No ○ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older?	0.08
Motor vehicle drivers under age 21?	0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-3)

Communities: 164

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

○ Yes ◉ No ○ Unknown

Missouri
Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Department of Mental Health - Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. CSTAR programs allow women and their children to receive multiple levels of care based upon the assessed needs. CSTAR programs are available in each region of the state, offering both rural and urban settings. ADA has maintained certification standards which require substance abuse treatment services for pregnant or postpartum women or women with custody of children be the first priority. During FY 2006, 589 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements.

Nurses are available at each agency to assist with medical needs and referrals. Community support workers assist consumers with coordinating social service needs identified during the assessment process. Childcare is provided on-site or the program makes arrangements for child care at licensed facilities.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at each agency. The monitoring visit includes the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with requirements. Certification surveys occur on a three year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care and children are receiving safe and appropriate childcare. Monitoring schedules are current and programs are in compliance.

FY 2008 (Progress)

The Division of Alcohol and Drug Abuse continues to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. During FY 2007, 522 pregnant women were admitted to substance abuse treatment services. Evidence-based treatment, including trauma-informed care and services, and co-occurring services continue to be implemented in these programs.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse will continue to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority as well as quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. An annual Safety and Basic Assurances Reviews that includes a review of contract, certification and block grant requirements will be completed for each agency. A certification survey of program practices and operations conducted by a team of treatment specialists will be completed every three years for each agency.

Missouri

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2006. In a narrative of **up to two pages**, describe these funded projects.

Attachment B (Part 1)

Treatment for women in the State of Missouri has been enhanced over the past eighteen years due in part to the Block Grant funds. The Missouri Department of Mental Health Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender integrated programs to creating programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the programs provide for licensed daycare services for the children accompanying their mothers to treatment. One program's on-site daycare has been accredited by the National Association for the Education of Young Children. The dependent children receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2006 Block Grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request to ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific group of women and their children. Women are defined as requiring treatment when their use of alcohol and other drugs has caused dysfunction in any area of their lives. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured, intensive treatment in the continuum of care, and is provided in a trauma sensitive environment. Services are provided five to seven days per week. Services include day treatment (group and individual counseling, group education, and structured recovery support activities), community support, family therapy, trauma coping skills, residential support and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation and Supported Recovery:
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their

families and community while continuing to receive an intermediate level of support and treatment. Services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are offered each week. Treatment is provided in a trauma sensitive environment and consists of a menu of services including group counseling and education, individual counseling, community support, family therapy, trauma coping skills and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, offering a minimum of three therapeutic activities weekly. Women who are assessed as not needing intense or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma sensitive environment and consists of a menu of services including group counseling and education, individual counseling, community support, family therapy, trauma coping skills and day care for dependent children. Age appropriate assessment and co-dependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Specialized Treatment

Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma, mental health education, and relapse prevention. Group counseling is offered to allow consumers to explore emotional issues and work towards healthy self image, relationships, and lifestyles. Individual counseling allows for further exploration and working towards specified individualized treatment goals.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State Certification Standards require each program to be a licensed daycare facility for children. A child therapist is required on each program staff to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless when they enter treatment may receive housing assistance from ADA while participating actively in treatment. Community housing is time limited and intended as a bridge to other, long term housing arrangements. The stipend for community housing is a maximum of $500 per month and can be used to pay rent, initial deposits, utilities and local telephone service.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses offer medical services, referrals, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The community support workers assist the consumers in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors provide prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. All CSTAR programs conduct an HIV/STD/TB risk assessment for all consumers at admission. Pre and post test counseling for HIV/AIDS, STD and TB are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

During FY 2007, a specialized communication protocol was developed to facilitate communication between primary care physicians (PCP), case managers for the Medicaid managed care plans, Women and Children CSTAR providers, and ADA's Clinical Utilization Review Unit. Pregnant women entering the Medicaid managed care system at their physician's office will be asked to consent to sharing only clinically relevant and appropriate information to improve continuity of care when screened by a CSTAR Women and Children provider. This will ensure pregnant women and their child will have access to all available treatment and support services that meet their specialized clinical needs.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY 2008, 6,297 women and children were treated in the CSTAR women and children programs. In FY 2008, 89 out of 97 babies born to women in CSTAR programs were born drug free. In addition, 110 children were returned to their mother's custody from the Children's Division because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized, outcome-based system of monitoring consumer improvement on numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on-going goals.

Missouri
Attachment B: Programs for Women (contd.)

Title XIX, Part B, Subpart II, ot the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2006 block grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2006 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B (Part 2)

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of General Revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary consumers and ten beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All of the women's' facilities have access to supportive housing money, and therefore can offer additional safe housing options.

The number of consumers served in FY2006 in all three levels of care at the women's treatment programs, by agency, was:
BASIC – 395;
Bridgeway Behavioral Health – 1052;
Family Counseling Center of Missouri, Inc. – 732;
Family Counseling Center, Inc. – 610;
Family Self-help Center – 521;
Hannibal Council on Alcohol and Drug Abuse – 474;
Alternative Opportunities – 670;
New Beginnings Alt-Care – 324;
Queen of Peace Center – 1153;
Renaissance West, Inc. – 543;
Research Mental Health Services – 894;
Research Mental Health Services Alt-Care 472;

A list of all women and children's CSTAR programs in Missouri, including the sub-State Planning Area (SPA) and the National Federal Registry (NFR) ID, is as follows:

Black Alcohol/Drug Service Information Center (BASIC)
3028 Locust
St. Louis, MO 63103
Allocated funds FY 2006 $521,710
SPA: Eastern Region
NFR ID: MO100880

Bridgeway Behavioral Health (formerly Bridgeway Counseling Services)
1570 South Main Street
St. Charles, MO 63303
Allocated funds FY 2006 $883,174

SPA: Eastern Region
NFR ID: MO101136, MO101458

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2006 $744,047
SPA: Central Region
NFR ID: MO101003

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63703
Allocated funds FY 2006 $763,067
SPA: Southeastern Region
NFR ID: MO101123

Family Self-Help Center
Lafayette House Serenity Program
Box 1765, 1809 Connor Avenue
Joplin, MO 64802
Allocated funds FY 2006 $617,155
SPA: Southwestern Region
NFR ID: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2006 $662,561
SPA: Northern Region
NFR ID: MO101219

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65801-1277
Allocated funds FY 2006 $651,225
SPA: Southwestern Region
NFR ID: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2006 $875,500

SPA: Eastern Region
NFR ID: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2006 $835,972
SPA: Eastern Region
NFR ID: MO100591

Comprehensive Mental Health Services (CMHS)
Renaissance West
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2006 $788,154
SPA: Western Region
NFR ID: MO100898

ReDiscover
(formerly Research Mental Health Services North Star Recovery Services)
(Two programs; Alt-Care women's Correctional and a Women and Children Program)
620 East 18th Street
Kansas City, MO 64108
Allocated funds FY 2006 Women and Children $785,554
Allocated funds FY 2006 Alt-Care Women's Correctional $875,500
SPA: Western Region
NFR ID: MO101094

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2006 Block Grant funds?

Treatment services for women in the State of Missouri have continued to expand due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve provider contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. One program's on-site daycare earned accreditation by the National Association for the Education of Young Children. Two of the CSTAR programs were designed in collaboration with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. Dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2006 block grant funds for at least a 5% set aside has been exceeded.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. All CSTAR treatment programs receive a site Certification Survey every three years from a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance treatment. In addition, Area Treatment Coordinators perform annual Safety and Basic Assurances reviews which include a review of compliance with Block Grant requirements. The Area Treatment Coordinators also provide technical assistance visits when necessary. Representatives from each women and children's program meet regularly to collaborate with ADA staff on developing issues and trends.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, the number of consumers, and consumer demographics (including pregnancy at admission). Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR – Women and Children's programs as funds became available.

5. What did the State do with FY 2006 Block Grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in CSTAR Programs has increased from 2,548 in FY 1995 to 7,276 in FY 2006.

Missouri
Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.
(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.
1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.
(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.
(C) The screening—
1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

The contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant." Opioid treatment providers were required to admit or refer individuals who abused intravenous drugs within the past thirty days or were in imminent danger of relapse. The Client Tracking Registration Admission and Commitment (CTRAC) information system, designed and maintained by the Missouri Department of Mental Health, has a registration screening/waiting option which could be used in lieu of program admission.

Once treatment became available, the consumer could then be transferred from the waiting list to a program enrollment. Since October 2006, the Division of Alcohol and Drug Abuse (ADA) has made available the waiting list monitoring option on the Customer Information Management, Outcomes and Reporting (CIMOR) system.

Provider contracts include provisions and requirements related to outreach activities. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the Certification Survey process and annual Safety and Basic Assurances Reviews which includes the Block Grant Requirement Checklist.

FY 2008 (Progress)

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Standards require that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed. Additionally, the contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant."

Opioid treatment providers are required to admit or refer individuals who abuse intravenous drugs within the prior thirty days who are in imminent danger of relapse. The Client Tracking Registration Admission and Commitment (CTRAC) information system, designed and maintained by the Missouri Department of Mental Health, has a registration screening/waiting option which can be used in lieu of program admission. Once treatment became available, the consumer could then be transferred from the waiting list to a program enrollment. Since October 2006, the Division of Alcohol and Drug Abuse (ADA) has made available this waiting list monitoring option on the Customer Information Management, Outcomes and Reporting (CIMOR) system. This allows ADA to identify intravenous (IV) drug users who are waiting for treatment. Providers have been encouraged to utilize the wait list function in CIMOR to assist departmental monitoring of waiting lists for IV drug users. Statewide, there are 3,003 consumers that identify themselves as using intravenous drugs and who have participated in contracted treatment.

Provider contracts include provisions and requirements related to outreach activities. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the Certification Survey process and annual Safety and Basic Assurances Reviews which includes the Block Grant Requirement Checklist.

ADA continues to use certification surveys and annual Safety and Basic Assurances Reviews with the Block Grant Checklist to review provider compliance with priority treatment for IV drug users. Agencies found to be out of compliance are identified and are required to provide an action plan to achieve contract and standard compliance. Technical assistance, consultation, and focused compliance reviews are applied to those treatment agencies serving IV drug users to ensure consistent compliance and the provision of high quality service to the high-risk IV drug abusing consumer.

FY 2009 (Intended Use)

The Customer Information Management Outcomes and Reporting (CIMOR) information system offers the capability to capture consumer screening/waiting data to monitor pending admissions for treatment. Providers will continue to be encouraged to utilize this wait list system in CIMOR to assist departmental monitoring of waiting lists for intravenous (IV) drug users. Consumers will be admitted to treatment, referred to other providers for immediate treatment or receive interim services until clinically appropriate treatment is available. The Division of Alcohol and Drug Abuse (ADA) will be amending provider contracts to more explicitly state requirements for admission and care of persons who are IV drug users. The contract language will offer examples of “interim services” that are required to be provided if admission time stipulations cannot be met. These services shall include a screening and providing the consumer with appropriate information to address urgent service needs including, but not limited to, printed information about local 12-step groups and other recovery support services in the area.

Missouri
Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))
For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2006 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C

1. Intravenous (IV) drug abusers include all substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously or intramuscularly.

2. Throughout FY 2006, all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs. Providers are contractually mandated to adhere to Block Grant requirements. No official notification of reaching 90% capacity is formally sent to the Division of Alcohol and Drug Abuse (ADA); however, when applicable, programs communicate with staff at the division's district offices regarding their capacity. If at capacity, programs make referrals to other resources in the community, for example, to private pay opioid or detoxification programs. The new Customer Information, Management, Outcomes and Reporting (CIMOR) information system for the Missouri Department of Mental Health (DMH) has a registration option of screening/waiting which can be used. ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurance Reviews (SBAR). Agency admissions of priority populations, including IV drug users, and management of waiting lists are discussed and monitored during certification and SBAR visits, as well as, during technical assistance visits that might be conducted throughout the year. Regional staff conducting these reviews are trained to understand contract requirements and to apply them to substance abuse treatment programs. Programs demonstrate compliance with capacity requirements by conducting a brief telephone screening and scheduling an assessment/admission date for individuals requesting service. Programs also demonstrate compliance by referring clients to other providers when unable to admit in a timely manner due to being at capacity. As part of the Access to Recovery (ATR) grant, Primary Recovery plus (PR+) programs are required to offer several provider options as part of the voucher system – documenting consumer choice in the State's treatment system.

3. Opioid treatment providers were required to admit persons who were IV drug users within the past thirty days or who were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. If at capacity, programs will make referrals to other resources in the community, for example, to private pay opioid programs or detoxification programs. The information system designed and maintained by DMH has waiting list functionality. ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed

informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurances Reviews.

4. ADA encourages certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address IV drug use. Providers are encouraged during certification surveys to engage consumer's families in treatment and to address family IV drug use. During the FY 2007 DMH Spring Training Institute, eight training sessions provided information relevant to IV drug use treatment protocols. ADA is collaborating with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA is collaborating with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug abuse. In FY 2008, two sessions of Spring Training Institute addressed opioid treatment. Expansion of the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Opioid program is under development for the city of St Louis.

Missouri
Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly funded system of care continue to remain at or near capacity. Monitoring procedures are in place to assist consumers in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the Regional Administrators and Area Treatment Coordinators. Prior to October 2006, the Client Tracking Registration Admission and Commitment (CTRAC) information system, designed and maintained by the Missouri Department of Mental Health (DMH), provided screening/waiting functionality. In October 2006, DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR), which offers treatment providers waiting list management for primary treatment with residential support. CIMOR is accessible to all the organizations that have contracts with the Division of Alcohol and Drug Abuse (ADA). ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have also developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. In addition, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised to consumers for providing treatment referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area.

No problems were identified and thus, no corrective action was taken.

2. Tuberculosis Services

ADA collaborates with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA requires contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided include educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services are provided to determine whether the individual has been infected with mycobacterial tuberculosis. Those testing positive receive referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide access to tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities are required to maintain collaborative relationships with their county health departments. Consumers may have access to testing and health care services at any time during their treatment. Agencies may not deny access to treatment based on a positive tuberculosis test result

providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment providers may request assistance from county health department staff to observe their consumers taking preventive medicine when a positive tuberculosis skin test is identified.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the consumer, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control, in determining appropriate services and available medical resources.

Training and education opportunities are available to provider staff through DMH and DHSS. The Division's treatment specialists, District Administrators, and Area Treatment Coordinators continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site Certification Surveys, Safety and Basic Assurances Reviews, and technical assistance visits, ADA monitors tuberculosis services including screening, referral, testing procedure, counseling, and consumer confidentiality. Certification surveys are conducted every three years. Safety and Basic Assurance Reviews are conducted during the years in which certification is not performed. Technical assistance visits are provided as needed.

The infection control recommendations and protocols for substance abuse treatment providers include, but are not limited to, the following procedures:

- screening of patients,
- identifying those individuals who are at high risk of becoming infected, and
- complying with all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems were identified and thus, no corrective action was taken.

3. Treatment Services for Pregnant Women

Contracts require that all service providers specializing in women's treatment must give priority to pregnant women seeking admission to treatment. The Department of Mental Health (DMH) - Division of Alcohol and Drug Abuse (ADA) maintains the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer these services to women and children suffering from the effects of substance abuse. CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. These programs are available in each region of the state. ADA has maintained certification standards which establish substance abusing pregnant or postpartum women or women with custody of children as a first priority population. CSTAR certification standards (9 CSR 30-3.190 Specialized Program for

Women and Children) state that “[p]riority shall be given to women who are pregnant or postpartum” and, “[t]he program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria.” During FY 2006, 589 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements. During FY 2007, 453 pregnant women received substance abuse treatment services.

Nursing services are available at the program site and a community support worker assists the consumer with necessary medical referrals and scheduling of appointments. At all CSTAR programs specializing in treatment of women and children, childcare is provided on-site or the program makes arrangements for childcare.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This review includes the Area Treatment Coordinator reviewing the program’s practices and Block Grant Requirement Checklist to ensure compliance. Certification surveys occur on a three year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance. As no problems were noted, no corrective actions were taken.

Missouri
Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. The DHSS serves as a repository for statistical data and as an information and training resource related to tuberculosis issues. There is a Memorandum of Understanding between ADA and DHSS with the purpose of combining "skills, experience, and expertise for the development of a collaborative educational effort designed to benefit the general public and those at high risk for health and mental health conditions." This collaborative effort is to provide for an integrated systems framework by which both entities will educate, through technical assistance, local providers contracted with ADA to provide substance abuse counseling services, in order to better serve the consumers. ADA has a representative attend Community Planning Group meetings that address a variety of issues related to communicable diseases. The ADA representative disseminates information to providers as it relates to TB services, information, and issues.

ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. This requirement was and is formalized, along with requirements for other communicable diseases, in contract language as follows:

4.5 **Communicable Diseases Risk Assessment, Education, Testing and Counseling**

4.5.1 The contractor shall have a working relationship with the local health department, physician, or other qualified healthcare provider in the community to provide any necessary testing services for Human Immunodeficiency Virus (HIV), tuberculosis (TB), sexually transmitted diseases (STDs), and Hepatitis.

a. The contractor shall arrange for HIV, TB, STDs and Hepatitis testing to be available to the consumer at any time during the course of the consumer's treatment.

1. The contractor shall make referrals and cooperate with appropriate entities to ensure coordinated treatment, as appropriate, is provided for any consumers with positive tests.

4.5.2 The contractor shall provide or arrange individual counseling for consumers prior to testing for HIV.

a. In the event the contractor elects to provide HIV pre-test counseling, counseling shall be provided in accordance with the State of Missouri Department of Health and Senior Services (DHSS) Rule (19 CSR 20-26.030), as mandated by state law. These requirements may be downloaded from the following site:

http://www.sos.mo.gov/adrules/csr/current/19csr/19c20-26.pdf

b. Contractor staff providing HIV pre-test counseling must be trained in accordance with DHSS requirements. The contractor shall be responsible for all costs associated with receiving any such training.

4.5.3 The contractor shall provide or arrange individual post-test counseling for consumers who test positive for HIV or TB.

a. Contractor staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the DHSS.

4.5.4 The contractor shall arrange and coordinate, as necessary, post-test follow-up for consumers who test positive for STDs or Hepatitis.

4.5.5 The contractor shall provide group education with substance abusers and/or significant others of abusers to discuss risk reduction and the myths and facts about HIV/TB/STD/Hepatitis and the risk factors for contracting these disease.

FY 2008 (Progress)

Contracted treatment providers are required to make tuberculosis (TB) skin testing available to all consumers in their programs. Providers are also required by contract to maintain effective linkages with local health departments to assist treatment program staff with consumer testing and monitoring efforts. TB post-test counseling funding is available as part of the Access to Recovery grant. Providers are monitored annually for compliance by the Safety and Basic Assurances Reviews process to ensure that TB-positive consumers are identified and receive treatment services and to ensure that effective referrals are made for health services in collaboration with local health departments.

The Missouri Department of Health and Senior Services (DHSS), as part of a Memorandum of Understanding with the Division of Alcohol and Drug Abuse (ADA), offers technical assistance and direct intervention at the community level to contracted providers to procure TB testing supplies. ADA participation in Community Planning meetings continue. The DHSS continues to provide follow-up diagnostic services for consumers who do not have health care resources. The DHSS has demonstrated their commitment to the provision of consistent TB services at the community level. This state department serves as a repository for statistical data and as an information and training resource related to tuberculosis issues.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to make tuberculosis risk assessment, testing, and risk reduction education available to all treatment consumers. The provision of tuberculosis specific services will continue to be monitored with annual Safety and Basic Assurances Reviews and certification site surveys. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that consumers will have access to and can participate in tuberculosis services. This requirement is established in contracts. Contracted providers will continue to receive ADA support, technical assistance, and direct intervention at the community level to access TB services. ADA will continue to offer technical assistance to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services (DHSS) community health departments. The DHSS will continue to serve as a repository for statistical data and as an information and training resource related to tuberculosis issues.

Missouri
Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

Missouri is not a designated state.

FY 2008 (Progress)

Missouri is not a designated state.

FY 2009 (Intended Use)

Missouri is not a designated state.

Missouri

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))
For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:
Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU) ;
• the role of the single State authority (SSA) for substance abuse prevention and treatment; and
• the role of the single State authority for public health and communicable diseases.

Examples of **activities** include, but are not limited to:
• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse ;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV ;
• the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

Attachment E

The Division of Alcohol and Drug Abuse (ADA) has provided TB and HIV services in the four publicly-funded methadone programs and other selected treatment programs since 1989. Linkages between early intervention services for HIV and the Intravenous Drug Users (IVDU) Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993, all substance abuse treatment programs have provided TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. During FY 2008 $454 was spent on TB tests by Department of Health and Senior Services (DHSS). All consumers, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the DHSS, local county health departments, and substance abuse programs to ensure services are available to all consumers.

In FY 2008 these services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. In FY 2008 $51,188 was spent on TB services for clients who were in substance abuse treatment. All consumers received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre-and post-test counseling, testing, and HIV education were available to consumers in substance abuse treatment. A total of $44,687 was spent on TB pre-and post-test counseling.

A Treatment Specialist from ADA maintained regular contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided by the Department of Mental Health, in the form of technical assistance and consultation. ADA adhered to the protocols established by the Centers for Disease Control and Prevention (CDC) and DHSS.

All offenders receiving substance abuse treatment within the Missouri Department of Corrections receive TB testing with a two step test at intake. This is performed and read by licensed nurses. Patient education is also provided. Testing is performed annually in the birth month or if symptomatic or exposed to an active case. Those who are symptomatic or have positive tests/x-rays/sputum are isolated in respiratory isolation. They remain there until TB is ruled out or until treatment is proven successful by negative sputum tests. Those with a positive test, indicating exposure, but without active disease are given prophylactic treatment directly observed by nursing staff. Those with active disease are given medication and housed in respiratory isolation until no longer contagious. Those exposed to active cases are tested. All positive tests are

reported to DHSS. If an active case is identified DOC works with the DHSS to develop an action plan. A total of $6,047 was spent by DOC on the above TB services.

The responsibility for public health and communicable diseases is a secondary role, requiring close coordination of policy and program priorities between DHSS and ADA. ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies the on going partnership related to prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to and utilization of HIV prevention and care services, STD, Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and regional cross-training are planned for delivery to all regions in the state as identified in the current MOU between DHSS and ADA.

Missouri

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2006 (Compliance): (Reporting REQUIRED if State chose to participate)
FY 2008 (Progress): (Reporting REQUIRED if State chose to participate)
FY 2009 (Intended Use): (State participation is OPTIONAL)

FY 2006 (Compliance)

In FY 2006, the Department of Mental Health, Division of Alcohol and Drug Abuse, opened one house for women and four men's Oxford Houses. A continued need for safe and affordable housing exists in Missouri and indications are this will be the case for many years to come. Housing specialists employed by the state continue to monitor and provide technical assistance to 43 houses for men and 11 houses for women.

FY 2008 (Progress)

The Department of Mental Health, Division of Alcohol and Drug Abuse, continues to support the Oxford House program within the State of Missouri. Through careful selection of prospective house locations, the stabilization of the Oxford House program has been maintained.

FY 2009 (Intended Use)

The housing needs of individuals in recovery will continue to be a high priority in the future. The State of Missouri will continue to support the group home program to assure adequate housing for individuals completing treatment and seeking safe and affordable housing. The Department of Mental Health, Division of Alcohol and Drug Abuse, will continue to assist in opening new houses and providing technical assistance to the Oxford House program.

Missouri
Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2006 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2006 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:
- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year ;
- the source of funds used to establish and maintain the revolving fund ;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered ;
- the private, nonprofit entity selected to manage the fund ;
- any written agreement that may exist between the State and the managing entity ;
- how the State monitors fund and loan operations ; and
- any changes from previous years' operations.

Attachment F

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25 penalty if not received as scheduled.

There were four (4) loans issued in 2006 totaling $14,300. The amount of funds available at the time of these loans was between $24,430 and $25,500. Other existing loans were being repaid while new loans were approved to open the new houses. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received. There have been instances of late payments or loan defaults during the past year due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching from a women to men's houses. However in FY 2006 there were 6 loans in default. When payment issues arise, a letter is sent to the house reminding them of their payment obligations. In cases where a house closes, the loan is reassigned to the Oxford House Chapter or another house until the loan is repaid.

On a monthly basis, the Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the Department of Mental Health, Division of Alcohol and Drug Abuse (ADA). Technical assistance is provided by the Drug Free Group Home Specialist and can be obtained through an 800 telephone number. Through publications, meetings, and workshops, ADA has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2006, 110 loans have been committed in Missouri for drug-free group homes. These homes are located in 12 Missouri cities. More than $343,300 has been loaned to open Oxford Houses in Missouri since 1989. There are 54 houses in the state where 348 men and 103 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

CENTRAL REGION

Alhambra
107 E Alhambra
Columbia, MO 65203
M 573-443-2640

Bicknell
104 Bicknell
Columbia, MO 65203
M 573-442-7084

Calico
2504 Calico St
Columbia, MO 65202
M 573-474-0035

Cougar
600 Rogers St
Columbia, MO 65203
M 573-442-2330

Elliott
220 Elliott Ave
Columbia, MO 65201
W 573-256-8501

Hubble
105 Hubble St
Columbia, MO 65201
W 573-499-0202

Leslie
19 E Leslie
Columbia, MO 65203
M 573-256-5221

Nelwood
2501 nelwood Dr
Columbia, MO 65202
M 573-814-0888

Pinewood
115 Pinewood Ave
Columbia, MO 65203
W 573-234-7449

Pioneer
1213 Pioneer St
Columbia, MO 65202
M 573-886-9550

Proctor
314 Proctor Dr
Columbia, MO 65202
M 573-874-9610

Quail
2614 Quail St
Columbia, MO 65202
M 573-814-3900

Sondra
921 Sondra
Columbia, MO 65203
M 573-875-5721

Willowbrook
2501 Willowbrook Ct
Columbia, MO 65203
M 573-474-0741

West Broadway
2402 W Broadway
Columbia, MO 65203
W 573-445-3699

EASTERN REGION

Allendale
3127 Meramec St
St. Louis, MO 63118
M 314-353-5823

Chippewa
6408 Chippewa
St. Louis, MO 63109
V 314-353-2771

Clayton
6957 Clayton Rd
St. Louis, MO 63110
M 314-863-7669

Fairview
2171 Hwy. 61
Festus, MO 63028
M 636-937-2514

EASTERN REGION (continued)

Gravois
3943 Gravois
St. Louis, MO 63116
M 314-772-1303

Humphrey
3542 Humphrey
St. Louis, MO 63118
M 314-865-2928

Jarman
4506 S. Grand
St. Louis, MO 63118
W 314-351-1567

Kensington
5058 Kensington
St. Louis, MO 63108
M 314-367-7962

Lusher
11876 Lusher Rd
St. Louis, MO 63138
M 314-741-7536

Lynncove
1751 Lynncove Lane
St. Charles, MO 63303
M 636-724-4562

McCausland
2017 McCausland
St. Louis, MO 63143
M 314-644-0971

McDonough
527 McDonough
St. Charles, MO 63303
M 636-947-6730

Michigan
7127 Michigan Ave
St. Louis, MO 63111
M 314-351-2712

Monitor
3633 Meramec
St. Louis, MO 63116
M 314-752-1213

Montana
3655 Montana Ave
St. Louis, MO 63116
M 314-351-2064

Oak Lake
11100 Oak Lake
Creve Couer, MO 63146
W 314-432-1544

Osage
2715 Osage
St. Louis, MO 63118
W 314-772-6771

Portis
4430 Arsenal St
St. Louis, MO 63118
M 314-776-5825

Shenandoah
720 Shenandoah
St. Louis, MO 63104
M 314-446-4883

St. Charles
225 N 5th Street
St. Charles, MO 63301
M 636-940-0741

Winfield
60 Franke
Winfield, MO 63389
M 636-566-6258

WESTERN REGION

Blue Hills
1832 E 49th St
Kansas City, MO 64130
M 816-923-7696

Felix
1419 Felix
St. Joseph, MO 64501
W 816-232-4773

Harrison
26 E Concord
Kansas City, MO 64112
M 816-237-1925

Hillcrest
9615 Freemont
Kansas City, MO 64134
M 816-761-3948

Holmes
2741 Holmes
Kansas City, MO 64108
M 816-842-1634

Hyde Park
3444 Campbell
Kansas City, MO 64109
M 816-216-1544

Karnes
3734 Walnut Ave
Kansas City, MO 64109
W 816-931-6731

Marlboro
1410 W 77th Terrace
Kansas City, MO 64131
M 816-333-2267

Museum Hill
1210 Felix
St. Joseph, MO 64501
W 816-676-2323

Raytown
10905 E 63rd Terrace
Raytown, MO 64133
M 816-358-6495

Rockhill
5632 Charlotte
Kansas City, MO 64111
M 816-362-8265

St. Joseph
507 S 10th Street
St. Joseph, MO 65401
M 816-232-8989

Truman
400 S Hocker
Independence, MO 64050
M 816-232-0222

SOUTHWEST REGION

Catalina
1674 S. Catalina
Springfield, MO 65807
M 417-887-7783

Kerr
953 W Kerr
Springfield, MO 65803
M 417-368-7052

Moffet
529 Moffet St
Joplin, MO 65804
M 417-623-4347

United
1558 Cherokee
Springfield, MO 65807
M 417-866-1183

SOUTHWEST REGION (continued)

Wall
1422 S Wall
Joplin, MO 65616
W 417-623-8984

TECHNICAL ASSISTANCE STAFF

1-800-575-7480 ADA Toll Free Number

M=Men
W=Women
V=Veteran

Jacquie Lockett
314-877-0386

Sherry Hill
816-482-5763

Missouri
Goal #8: Tobacco Products

GOAL # 8.

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2009 Annual Synar Report included with the FY 2009 uniform application? (Yes/No)

- If No, please indicate when the State plans to submit the report: (mm/dd/2008)

Note: The statutory due date is December 31, 2008.

Missouri plans to submit the FFY 2009 Annual Synar Report with the FFY 2009 SAPT Block Grant application.

Missouri

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) provides specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given priority admission. Monitoring procedures were in place to assist pregnant women in accessing treatment as quickly as possible. Agency activity levels were monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by DMH includes a registration option of screening / waiting in addition to the regular program admission function. ADA encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care were available. Agencies within close proximity of each other developed informal telephone communications to refer consumers to other programs when they were unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. In addition, ADA assisted agencies in locating treatment services throughout the state. ADA had a toll-free number advertised for consumers to call for referrals. Central office or regional staff received the calls and made referrals to treatment programs in the consumer's area. Compliance was monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

FY 2008 (Progress)

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. Compliance continues to be monitored by Certification Surveys and annual Safety and Basic Assurances Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district office staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required.

During FY 2008 the Division of Alcohol and Drug Abuse (ADA) implemented a protocol to facilitate referral of pregnant women in Medicaid Managed Care in need of substance abuse treatment to Women and Children's Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. This protocol is formally known as the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. The protocol guides collaboration between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

One component of the protocol is the expectation that the CSTAR providers involve primary care providers and health plan case managers in the pregnant women's continuing care plans. The ADA Clinical Utilization Review Unit monitors referral to CSTAR treatment programs through the protocol and promotes communication between the primary care providers and health plan case managers. The Clinical Utilization Review Unit submits quarterly reports to the Missouri HealthNet Division that track referrals and follows communication activities and issues for review.

FY 2009 (Intended Use)

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. Compliance will continue to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

The Division of Alcohol and Drug Abuse (ADA) will continue its participation in and promotion of the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. The protocol guides collaboration between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services. Medicaid managed care is currently only available in certain regions of Missouri; thus, only those Women and Children's CSTAR programs located within those regions initially participated in the protocol. Given the prioritization of pregnant women to treatment, it is reasonable that some women from the managed care coverage area may need to obtain treatment through an out-of-network provider. Thus, in late FY 2008, the remaining Women and Children's CSTAR programs in the state were invited to participate in the protocol. One program began participation before the end of FY 2008. ADA is communicating with the other two programs to educate them about the protocol and encourage their involvement in FY 2009.

The ADA Clinical Utilization Review Unit will continue to monitor referrals to CSTAR treatment programs through the protocol and promote communication between the primary care providers and health plan case managers. The unit will continue to submit quarterly reports to the Missouri HealthNet Division on the progress of the protocol.

Missouri
Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))
For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:
In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system ;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment ;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment ;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in standards which guide providers of treatment services through the Certification Standards for ADA programs. These Certification Standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires (A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the ADA conduct clinical review to "promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires "the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."

Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating referral resources throughout the state.

The certification standards are part of the ongoing operations of ADA. In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can

be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information systems:
The Client Tracking, Registration, Admission and Commitment (CTRAC) information system designed and maintained by the Missouri Department of Mental Health (DMH) had a registration option of screening/waiting in addition to the program admission function. The use of this system was discontinued in September 2006.

DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR) at the beginning of October 2006, which offers all organizations the option of using a tool in this system to manage waiting lists. This is available for access to all the organizations that have contracts with ADA. Providers are encouraged by ADA to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

The CTRAC and CIMOR systems are components of the DMH's consumer information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number and ADA Website

ADA has a toll-free number advertised for consumers to call in for referrals. Either central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area. In addition, ADA maintains a website, which provides the public with information regarding substance use and links to treatment facilities.

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users. When members of these priority populations present for services, they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs. While treatment services at any level and intensity can be immediately available to members of these populations, agencies offering the residential component do not always have beds available. In such situations, the ADA policy has required the agency to transition a clinically stable consumer who is not a member of a priority population from residential support to transitional or supportive housing or other appropriate housing plan, thereby ensuring room in the residence for the priority population consumer.

The above procedure has worked reasonably well in light of limited resources. Compliance with this procedure will be monitored by Certification Surveys and annual

Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

Missouri
Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Addiction Severity Index (ASI) was the primary assessment tool used to determine level of care for consumers age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the consumer's admission. This assessment tool encompasses seven areas of life function: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status. In FY 2006, this assessment was accessible to contracted providers and the Division of Alcohol and Drug Abuse (ADA) via the web-based data collection interface "Outcomes Web." Data was transported over a Virtual Private Network for confidentiality. Assessment data was also included in the service authorization system in use in FY 2006, the Missouri Service Authorization System (MSAS).

The Missouri Adolescent Comprehensive Substance Assessment (MACSA) was designed by a workgroup of Missouri adolescent treatment providers and was in use in FY 2006. The MACSA is a structured clinical interview which is typically conducted at the time of the adolescent's admission to treatment. This assessment tool encompasses seven areas of life function: legal; school and work; behavior and emotions; friends; family; recovery environment; and placement. MACSA scores were also available in the MSAS system.

ADA staff reviewed assessment and utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers utilized the computerized ISAP to assure consumers were provided the most appropriate level of care. The tools used in the assessment process provided the ability to perform utilization review and outcome measurement.

Assessment results should guide assignment to an appropriate level of care. In addition to Division guidelines on level assignment using assessment information, certification standards outline eligibility requirements for admission into each level of the continuum of care:

9 CSR 30-3.120 Detoxification
(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for one self;

(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment

(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:

1. Recent patterns of extensive or severe substance abuse;
2. Inability to establish a period of sobriety without continuous supervision and structure;
3. Presence of significant resistance or denial of an identified substance abuse problem; or
4. Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person:

1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or
2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment

(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on:

1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and
2. Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;
2. Absence of crisis that cannot be resolved by community support services;

3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and

4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:

1. Lack of need for structured or intensive treatment;
2. Presence of adequate resources to support oneself in the community;
3. Absence of crisis that cannot be resolved by community support services;
4. Willingness to participate in the program, keep appointments, participate in self-help, etc.
5. Evidence of a desire to maintain a drug-free lifestyle;
6. Involvement in the community, such as family, church, employer, etc.; and
7. Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of ADA; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit monitored agencies' level assignments to the initial level of care given information provided via the MSAS system, the Outcomes Web, and clinical information supplied by providers during the utilization review process. Any concerns related to the referral of individuals to the most appropriate treatment modality could then be followed up on with the providers and appropriate ADA staff. The certification standards outlining the clinical utilization review process are as follows:

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;
2. Service authorization beyond any specified maximum amount or cost;
3. Admission of adolescents into adult programs; and
4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

Another important avenue to providing the most appropriate treatment modality to individuals seeking substance abuse treatment is access to specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The Division of ADA maintained contracts with CSTAR programs throughout the state to provide specialized services to populations including women and children, adolescents, and opioid dependent consumers.

The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange daycare and therapeutic services for children who accompany their mother in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to consumers between the ages of twelve and seventeen inclusive, and their families. These programs focus on therapeutic issues relevant to adolescents including recovery issues such as peer relationships, use of leisure time, and abuse and neglect; skill development such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate. The opioid CSTAR programs are designed to utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle.

FY 2008 (Progress)

Eligibility criteria are defined in certification standards. Assessment Severity Index (ASI) assessment results and eligibility criteria are to be used when determining the most appropriate treatment modality for adult consumers. In FY 2007, CSTAR adolescent providers discontinued use of the Missouri Adolescent Comprehensive Substance Assessment (MACSA) and began using the Global Assessment of Individual Needs (GAIN) assessment instrument at admission. The latter is a research-based full bio-psycho-social assessment that integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN provides a comprehensive, standardized tool with which to ensure appropriate consumer placement and service referrals. Adolescent programs continue to use the GAIN in their assessment and placement activities.

The Division of Alcohol and Drug Abuse (ADA) maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children, adolescents, and opiate-dependent consumers. During FY 2008, there were twelve (12) women and children's CSTAR programs (includes two Alt Care programs specializing in treatment for women released from correctional institutions), fourteen (14) adolescent CSTAR programs, and three opioid CSTAR agencies providing these specialized services in Missouri. The general population CSTAR programs and the community-based Primary Recovery Plus (PR+) programs continue to offer an array of community-based clinical substance abuse treatment services within multiple levels of care, based on the consumer's assessed needs. These services are delivered according to the genuine, free, and independent choice of provider, appropriate for the consumer's assessed needs.

The original award of Access to Recovery (ATR) funds allowed the enhancement of all existing primary recovery programs to provide the full array of services including relapse prevention and trauma services. In some cases, services were expanded into areas that are underserved. In other areas, nontraditional and faith-based organizations have been credentialed to provide recovery support services in their communities. Specific recovery support services available from credentialed nontraditional and faith-based organizations through the ATR grant include: re-entry coordination, care coordination, childcare, drop-in center, emergency/temporary housing, family engagement, pastoral counseling, individual and group recovery support, spiritual life skills, and transportation. As of June 30, 2008, there were 74 recovery support providers credentialed and contracted to provide these services. The Missouri Institute of Mental Health (MIMH) serves as the contractor for technical assistance on consumer tracking and follow-up data collection for the ATR project.

In an effort to better meet the needs of consumers with co-occurring mental health disorders, enhance the quality of care, and promote provider utilization of evidence-based practices, additional services were added to the service menus of all contracted

providers in FY 2008. These services include the following: Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, advanced practice nurse, or psychiatrist), Extended Day Treatment (nursing service), Medications and the Clinical Supervision of Counselors.

The Clinical Utilization Review unit continues to review authorization requests and assessments for compliance with certification standards, as well as, for appropriateness of placements in the continuum of care and specific clinical services made available to consumers. Data regarding provider trends in level assignment are available in CIMOR.

FY 2009 (Intended Use)

Contracted providers of substance abuse services will continue to use the Assessment Severity Index (ASI) for adults or the Global Assessment of Individual Needs (GAIN) for adolescents. Training and maintenance support of the GAIN assessment will be provided by provider and the Division of Alcohol and Drug Abuse (ADA) GAIN-certified local trainers. ADA will continue to review utilization data to identify patterns of success by provider agencies. ADA is working on fine-tuning the ability to retrieve data in a meaningful fashion. Several division staff members have attended and will attend further training on reporting in the system using various tools and databases. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data are being collected to meet the federal requirements.

In a cooperative effort to provide more access to substance abuse treatment in the St. Louis metropolitan area, the Division of ADA entered into a CSTAR General Population contract with the Hopewell Center at the outset of FY 2009. This agency was already providing contracted services to individuals with psychiatric disorders via a contract with the Department of Mental Health's Division of Comprehensive Psychiatric Services. The St. Louis Mental Health Board (MHB) selected the CSTAR treatment model for Medicaid-eligible consumers of the Hopewell Center that met criteria for CSTAR services. The St. Louis MHB will provide the match portion of the funding for services provided under this contract. The Division of ADA will monitor service provision through established mechanisms (Safety and Basic Assurance Reviews, Certification Surveys, and Utilization Review).

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation is incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All clinical treatment providers are required to collect and enter Treatment Episode Dataset (TEDS) data into the CIMOR system at appropriate points through consumers' episodes of care. In addition, primary recovery programs collect Government Performance Reporting Act (GPRA) data at intake, discharge and at 6-months post-admission. Treatment effectiveness is measured using the National Outcomes Measures domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery.

The Missouri Institute of Mental Health will continue to serve as the contractor to provide technical assistance for consumer tracking and collection of follow-up data for the Access to Recovery project.

The clinical utilization review unit will continue to review authorization requests and associated assessments for compliance with certification standards, appropriateness of placements in the continuum of care, and acceptable standards of care.

Missouri
Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 17-20, 2006 with 880 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care and cultural and linguistic competence, criminal justice, ethics, treatment planning for successful community outcomes, effective models for prevention in the treatment setting as well as other current issues impacting the substance abuse field.

Regional Collaborative Model trainings provided subsequent cross-training opportunities for the Division of Alcohol and Drug Abuse (ADA) and the Department of Health and Senior Services (DHSS) contracted providers. Participating DHSS and ADA treatment staff were provided with updated regional epidemiological data and responsive risk reduction methods to address consumer health risk factors associated with HIV/AIDS, STDs, TB, and Hepatitis. Regional collaboration plans were revised and updated to reflect the current progression of this regional service delivery model. Through regional trainings, additional action steps were identified to increase collaboration, resource development, and regional responsiveness.

ADA worked collaboratively in partnership with DHSS to provide the HIV pre- and post-test counseling training to DMH contracted provider staff. The DHSS has made the commitment to ADA to make their HIV trainings open to all ADA provider staff at no cost to the providers. ADA provider staff has been encouraged to pursue this required training at the regional level with their DHSS and local Department of Health staff.

ADA continued to provide training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The training focus included community assessments, capacity building, and measurable outcomes. ADA also continued to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance were provided to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA collaborated with CSAP's Southwest Center for the Application of Prevention Technology to provide training and technical assistance for targeted prevention initiatives.

FY 2008 (Progress)

The Department of Mental Health's annual Spring Training Institute was held May 14-16, 2008 and attended by approximately 1,300 professionals from the substance abuse prevention, substance abuse treatment, and mental health fields. National and local experts shared information about a wide range of evidence-based practices including trauma informed care cognitive-behavioral treatment issues, evidence-based prevention, medication assisted treatment, motivational interviewing, faith-based recovery support, and services for returning veterans experiencing mental health and/or substance abuse issues. The Missouri Division of Alcohol and Drug Abuse (ADA) Clinical Services Team provided technical assistance and training sessions to treatment providers including ethics; implementation of the Consumer Information Management, Outcomes, and Reporting (CIMOR) system; accessing services; the certification process; and documentation.

ADA Access To Recovery (ATR) staff presented a series of trainings to Missouri's clinical treatment and recovery support providers, with sessions tailored to meet the needs of the staff in each agency. ATR staff conducted training sessions during the fiscal year including Government Performance and Results Act (GPRA), ATR Overview, and ATR Voucher Management. ADA/ATR staff has also completed on-site Safety and Basic Assurance Reviews which involve technical assistance at the recovery support agencies. These visits included one-on-one training on documentation, proper invoicing techniques, ATR voucher management, and improving business practices. Regional informational meetings were held at least quarterly in St. Louis, Kansas City, Southeast, Southwest and Central Missouri. At least 50 of these continuing education events have occurred during the 2008 fiscal year.

ADA has continued to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance concerning community development, accountability, and targeted prevention initiatives were based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA has continued its close collaboration with Southwest Center for the Application of Prevention Technology (SWCAPT) to provide training and technical assistance for targeted prevention initiatives. The SWCAPT was designated to provide technical assistance to the Workforce Development Committee, known as the Missouri Prevention Network, to identify core competency requirements for levels of certification for prevention professionals. The SWCAPT continued to provide technical assistance to ADA to support the Strategic Prevention Framework State Incentive Grant (SPFSIG) as community coalitions implemented their evidence-based programs. ADA regional prevention specialists continue to provide technical assistance and training to the Missouri School-based Prevention Intervention Resources Initiative (SPIRIT) programs to assist with their implementation of science-based interventions.

ADA has continued to attend and to support the Department of Health and Senior Services (DHSS) in their efforts to host the Statewide Hepatitis C Planning Group. This

workgroup serves to support Missouri's efforts to disseminate Hepatitis C information and to continue to provide current materials to all ADA providers. No additional Regional Collaborative Model trainings are planned for this year.

ADA has continued to collaborate with the DHSS to provide regional HIV pre- and post-test counseling trainings to substance abuse provider staff. The DHSS provides materials and training curriculum as identified by the Centers for Disease Control and Prevention. Under the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MFASRAPP) initiative with the DHSS, selected women and children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers were trained to provide the Healthy Balance Intervention model of risk reduction to participating female consumers and to conduct screening for fetal alcohol syndrome (FAS). Continued in-service training for screening of FAS children has been provided to the staff of each participating CSTAR provider.

Under the MFASRAPP initiative with the DHSS, selected Women and Children's CSTAR providers continued to receive training and technical assistance to provide the FAS model of risk reduction, "Healthy Balance", to participating female consumers and to effectively conduct screening for FAS at the five participating Women and Children CSTAR sites. This was the final year of funding for the FAS grant.

FY 2009 (Intended Use)

The Department of Mental Health's annual Spring Training Institute will be held May 27-29, 2009. Continued collaboration with the Mid-America Addiction Technology Transfer Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention (CSAP) will ensure that employees of treatment and prevention agencies in Missouri receive training and education to promote the use of evidence-based practices. The Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff will continue to provide training to the clinical treatment and recovery support providers throughout the state. In the coming year, this training will consist of technical assistance visits at each of the new provider locations. These on-site trainings will include proper documentation and invoicing techniques as well as provide information on appropriate business practices. ADA/ATR staff will continue to partner with Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation, in presenting the Addictions Academy which is designed to educate recovery support providers on best practices in the field of addiction counseling and the faith communities' role in helping consumers recover. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system will be available to both clinical and recovery support providers upon request.

ADA will continue to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance will be focused on community development, accountability, and targeted prevention initiatives and will follow CSAP's best practices program recommendations. The Southwest Center for the Application of Prevention Technology (SWCAPT) will continue to provide technical assistance to ADA until January 31, 2009 to support the Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions continue to implement their evidence-based programs. ADA will continue to provide training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders to support their capacity to respond to community level prevention efforts supported with SPFSIG. ADA regional prevention staff will continue to provide technical assistance and training to the School-based Prevention Intervention Resources Initiative (SPIRIT) programs to encourage their utilization of best practice and science-based intervention services. The ADA Clinical Services Team will continue to provide technical assistance and trainings to providers and agencies within the community.

ADA plans to continue their partnership with the Department of Health and Senior Services (DHSS) to provide HIV pre- and post-test counseling training to substance abuse provider staff. The training curriculum will be directly provided by DHSS regional training staff and will meet the federal guidelines of the Centers for Disease Control and Prevention. The Collaborative Model initiative, in partnership with the DHSS, will be continued with active ADA membership and participation in the statewide Community Planning Group. Knowledge exchange and information sharing is promoted among the HIV prevention contractors and ADA providers. The relationships developed at the

regional level will continue to be encouraged and fostered within the workgroup environment.

Missouri
Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

In FY 2006, Treatment services were coordinated with prevention activities and other appropriate services in the following manner:

The advisory council network continued to be an important link between the public and the Division of Alcohol and Drug Abuse (ADA). The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), is established by State Statute and is an advisory body to the Director of ADA and its director. The SAC is comprised of 25 members appointed by the ADA director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services and no more than one-fourth can be ADA treatment or prevention contract providers. The SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol and other drug abuse. The SAC reviews current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public treatment programs, and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The following certification standards contribute to the coordination of treatment services. Certification standard 9 CSR 10-7.010 Treatment Principles and Outcomes states the following:

(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

Adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standard 9 CSR 30-3.192 (3) (F) requires the following:

Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas.

Coordination of education for adolescent consumers during treatment is required by standards. All consumers in CSTAR programs are offered a community support worker whose responsibilities include "activities with or on behalf of a particular consumer in accordance with an individual rehabilitation plan to maximize the consumer's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting consumer independence and responsibility." The community support worker arranges, refers, and monitors services external to the CSTAR program.

Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: build self esteem; learn to identify and express feelings; build positive family relationships; develop decision making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe drug free environment.

All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the

Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV, TB, STD, and hepatitis risk assessments for all consumers. High risk consumers were provided pre-test counseling, testing referral, and post-test counseling services. ADA designated staff continued to serve as liaisons with DHSS and ADA contracted treatment providers to respond to incidents or questions and to provide assistance with dissemination of infectious disease information.

ADA continued to work collaboratively with the DHSS on the Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA continued training the five participating Women and Children's CSTAR programs as needed. The training included fundamentals of Motivational Interviewing and instructions for providing the Healthy Balance Intervention Strategy to eligible women receiving treatment in the five CSTAR programs. Additional educational FAS curriculum continued to be used by the participating CSTAR sites for consumer education.

ADA continued support for the Missouri School-based Prevention and Intervention Initiative (SPIRIT) in the existing five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program continued to provide evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in the SPIRIT initiative included Positive Action, Life Skills Training, Second Step, Too Good for Drugs, Project Towards No Drug Abuse, Peace Builders, and Reconnecting Youth. Outcome measurement included use of the Teacher Observation Checklist (K-3), the Fidelity and Quality of Program Implementation Report, a revised Healthy Kids Survey (grades 4-5), the SPIRIT Survey for (grades 6-12), and the Youth Satisfaction Survey.

FY 2008 (Progress)

Missouri was awarded an Access to Recovery (ATR) Grant, in 2004 that provides $7.6 million per year for three years to implement a statewide treatment voucher system. Funding from this grant improved coordination and available alternatives among an increased number of qualified service providers; provided recovery support services through traditional, non-traditional, and faith-based organizations; and expanded the existing managed care system. Faith organizations and other nontraditional providers interested in providing recovery support services under the ATR project are required to become credentialed which requires participation in a 32-hour Addictions Academy. The Division of Alcohol and Drug Abuse (ADA) is also currently reviewing the system of care for individuals with co-occurring psychiatric and substance use disorders as part of the Co-Occurring State Incentive Grant. Six agencies are collaborating on this project.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by State Statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures to be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. During FY2007, the SAC established a Treatment and a Prevention subcommittee to collaborate with appropriate ADA staff, provide feedback and provide suggestions into the planning and budget process for ADA activities.

Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standards continue to require ADA and contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of consumers. ADA has provided numerous technical assistance visits and statewide meetings of providers to facilitate creative collaborative relationships with community resources. Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. ADA continues to collaborate with

DOC on their Missouri Reentry Program which was initiated with the Transition from Prison to Community Project. The primary objective of this program is to assist transitioning offenders with effective linkages to community treatment and mental health resources.

The Division of ADA and contracted providers continues to be actively involved in disease prevention activities in collaboration with the Department of Health and Senior Services (DHSS) which include screening, risk reduction assessment and education, and treatment of active diseases. The third phase of regional collaborative model cross-training for contracted prevention and substance abuse providers and regional community health prevention and care staff was provided during the fall of 2006. Regional action plans directed the focus of this training to be the prevention of Hepatitis C and risk reduction intervention strategies. Subsequent regional training and technical assistance will be provided as staff training needs are identified.

The Division of ADA continues to partner with DHSS to coordinate the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP), a five-year prevention initiative funded by the Centers for Disease Control and Prevention (CDC) to focus Fetal Alcohol Syndrome Disorder prevention services in rural counties. Under the MOFASRAPP, selected women and children's CSTAR providers continue to receive training and technical assistance on the Fetal Alcohol Syndrom (FAS) model of risk reduction, "Healthy Balance." This is the final year of funding for this initiative.

The Division of ADA continues the Missouri School-based Prevention and Intervention Initiative (SPIRIT). The Missouri SPIRIT program provides evidence-based prevention programs to 6,588 students in grades K–12. The curricula used are Positive Action, Life Skills Training, Peace Builders, Two Good For Drugs, Second Step, Project Towards No Drug Abuse, and Reconnecting Youth. Prevention providers assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT objectives are to delay onset of chemical use, decrease substance use, improve overall school performance, and reduce violence. The Missouri Institute of Mental Health has continued to provide program evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 3,938 students participated in the evaluation during FY 2008. The following measures continue to be used: Teacher Observation Checklist (K-3), SPIRIT Fidelity and Quality of Program Implementation Report, Healthy Kids Survey (grades 4-5), and the SPIRIT Survey (grades 6-12). Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age, and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

In FY 2007, Missouri had its Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan approved. All 18 coalitions are now in the implementation phase of their projects. SPF SIG staff continues to provide training and technical assistance to the SPF SIG recipients to help them with implementation, strategic

planning and evaluation. State-level SPF SIG staff and Chuck Daugherty, Missouri's Southwest Center for Application of Prevention Technology (SWCAPT) representative, also provided individual technical assistance at the trainings and at follow-up site visits. Missouri's state priority under this grant is to reduce risky drinking for persons aged 12-25 years.

The State Epidemiological Outcome Workgroup (SEOW) began implementing a Learning Community website to assemble resources and links for training, technical assistance, consumption and consequences data, program strategies, and program outcomes. The SEOW developed a format for hosting presentations by data specialists, with attendance open to the SPF SIG Governor's Advisory Committee and staff of the SPF SIG Community Coalitions.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education and family services will continue to be addressed in Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. Specialized programs will continue to provide treatment for adolescents, the opiate addicted, pregnant women, and women with dependent children. These programs provide additional programming and also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of these populations. The Co-Occurring State Incentive Grant project will continue to identify and implement system changes to meet the needs of consumers with co-occurring disorders and improve the integration of substance abuse treatment with existing mental health services.

Missouri has been awarded Access to Recovery (ATR) II grant funding to continue the system gains achieved in ATR I. ATR II will use faith based and non-traditional recovery support providers to emphasize the use of recovery supports during pretreatment or in less intense levels of outpatient care. Access to recovery support services will also be expanded to include consumers discharged from correctional facilities in an effort to help bridge the transition between institutional life and community based substance abuse treatment. Recovery support will also be expanded to include consumers enrolled in CSTAR Women and Children programs.

The Office of Faith Based and Community Partnerships was established in March 2007. This office will continue to coordinate the efforts of faith based recovery support providers with those of the substance abuse treatment and prevention providers and ADA staff.

The Division of ADA and contracted providers will continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction, assessment, education, and treatment of active diseases. Continued regional collaborative trainings will be planned to support the use of timely epidemiological data and to strengthen collaborative partnerships between ADA and DHSS providers.

The Division of ADA will continue to provide funding for program implementation and evaluation at the five School-based Prevention and Intervention Initiative (SPIRIT) sites. Evaluators will continue to track the number of referrals made through the project. Performance measures will include the Teacher Observation Checklist, the California Healthy Kids Survey, the Missouri Student Survey, the SPIRIT Fidelity and Quality of Program Implementation Report, the Youth Satisfaction Survey, and the teacher responses obtained from the SPIRIT Initiative Questionnaire. In collaboration with the Missouri Department of Elementary and Secondary Education, ADA will continue to support the Internet-based administration of the Missouri Student Survey in all Missouri

school districts. Local districts and ADA will continue to use survey results for planning and program development.

The State Epidemiological Outcome Workgroup (SEOW) will continue to promote cooperation and coordination with other substance abuse data system gatekeepers and users to enhance data quality, specificity, and utilization. The SEOW will focus particular attention on Missouri data from the Behavioral Risk Factor Surveillance System (BRFSS), the Missouri Information for Community Assessment (MICA) system, Missouri pharmaceutical databases, and data submitted by the SPF SIG coalitions for inclusion in the Learning Community website. The SEOW plans to develop additional data products using national and state data from the National Survey on Drug Use and Health, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey. The SEOW will explore new avenues for conveying substance abuse epidemiology information to policy makers, planners, prevention project implementers, and other stakeholders.

All of the Strategic Prevention Framework State Incentive Grant (SPF SIG) coalitions are in the implementation phase. The SPF SIG Governor's Advisory Committee will continue to review the goals contained within our state strategic plan.

Missouri
Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The treatment needs estimates provided in Forms 8 and 9 originated in one of the reports from Missouri's second State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under the Center for Substance Abuse Treatment (CSAT) Grant No. 5H79 TI12229. The data in Forms 8 and 9 were published as supplemental tables in the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*, RTI International, September 2003. The tables were requested by the Missouri Division of Alcohol and Drug Abuse (ADA) expressly to prepare the FY 2005 SAPT Block Grant Application and subsequent applications. RTI International formatted the tables to match Forms 8 and 9 (OMB No. 0930-0080). The Form 8 table provided treatment needs estimates for each ADA Region and Service Area for the total population, IV drug users, and women based on the STNAP-II needs assessment rates for demographic groups. The tables for Form 9 provided breakouts of the total population treatment needs estimates for each Region by age group, race (White and All Other), and gender. The treatment needs estimates were used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates were also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm).

During FY 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2003-2004 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates--and Missouri population estimates--for several measures and indicators from the survey. These tables were included in ADA's *Status Report on Missouri's Alcohol and Drug Abuse Problems.* Due to the availability of the NSDUH state data, ADA updated the prevalence estimates from the STNAP-II study that was conducted during the years 2000-2003. The updates reflected 1) population changes that occurred between Census 2000 (the population base used in the STNAP-II study) and 2004, and 2) the new NSDUH estimates for Missouri developed by SAMHSA's Office of Applied Studies. ADA used the estimated number of individuals with "alcohol or illicit drug dependence or abuse" as the measure of treatment need. The population adjustments in the STNAP-II estimates and the prevalence estimates from the NSDUH were combined to produce a new set of treatment need estimates for the ADA service areas and planning regions by age group, gender, and race/ethnicity.

The School-based Prevention and Intervention Initiative (SPIRIT) third year report was published in Spring 2006. SPIRIT was developed to delay onset and decrease use of substances, improve overall school performance, and reduce school-related violent incidents. Three classifications of data--individual, school, and program fidelity--were collected from 1581 students.

The Division of ADA continued to develop a systematic, data driven approach to estimate statewide and regional prevention needs. In FY 2005, ADA (and the Governor's Office) was awarded the Strategic Prevention Framework State Incentive Grant to provide funding for community coalitions to plan and implement data-driven prevention projects. Missouri began the steps of the Strategic Prevention Framework, including developing a Governor's Advisory Committee for the Grant. In FY 2006, the Governor's Advisory Committee continued to meet and give guidance to ADA on the priority population for the funding.

FY 2008 (Progress)

In determining treatment needs estimates provided in Forms 8 and 9, the State uses a combination of data sources including the National Survey on Drug Use and Health (NSDUH) surveys and the Missouri State Treatment Needs Assessment Program (STNAP-II) study, conducted in 2000-2003 under CSAT Grant No. 5H79 TI12229. From the STNAP-II study, data was made available by demographic factors including gender, race (white and non-white), and age groups (18-24, 25-44, 45-64, and 65 and over) by substate planning region. The STNAP-II sample size was insufficient to provide breakdown on the 12-17 age cohort as well as on the non-white racial cohorts. Data for the non-white racial cohorts are synthesized by applying treatment admission rates. For the 12-17 age cohort, the rates for the 18-24 age cohort are used as a proxy for the factors race and gender.

In determining the total population needing treatment services, the estimate for total population in need (477,000) was obtained from the National Survey on Drug Use and Health (NSDUH) 2005-2006. Treatment need is based on the percentage estimates of "alcohol or illicit drug dependence or abuse within the past year". The substate rates were obtained from the NSDUH 2004-2006 and applied to the 2005 population age 12 and over for each planning area. This distribution among substate planning areas was then used to allocate the current 477,000 total in need. This represents a change in methodology since previous Substance Abuse Prevention and Treatment Block Grant applications whereby the State based substate population estimates on the results from the Missouri State Treatment Needs Assessment Program (STNAP-II) study, conducted in 2000-2003. The primary reason for changing the methodology in favor of the NSDUH substate data is that STNAP-II tends to under-estimate the need in Northwest Region, in particular Jackson County. According to STNAP-II, the need in Northwest Region accounts for 17% of the State's need. In comparison, the NSDUH data indicates that this need represents 24% of the State's need.

In August 2008, the State submitted a data request through the State's Center for Substance Abuse Treatment (CSAT) project officer to get percentage estimates of women dependent on or abusing alcohol or illicit drugs in the past year based on 2002-2007 NSDUH data. This data was provided by CSAT in time to incorporate into the State's needs assessment for the FY 2009 Block Grant application. Using population-adjusted STNAP-II data, the number of women in need was estimated to be 147,246. The NSDUH data, however, puts the estimate at 190,000 – which was used in form 8 and form 9. The Division was particularly grateful to CSAT for providing this data as ADA is seeking, through a new budget item, an expansion of the Women's program in under-served areas.

The updated estimates are being used to calculate treatment penetration rates; plan and allocate treatment services; prepare presentation materials for the state legislature and other policy makers; and develop ADA's portion of the Department of Mental Health's annual budget request for FY 2010. The estimates were also summarized in

the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm).

The Missouri Department of Elementary and Secondary Education (DESE) and ADA continues to collaborate in supporting and promoting the Missouri Student Survey, an instrument that collects data on substance abuse incidence and prevalence; delinquent behavior; and risk and protective factors related to a range of health and safety issues. In the spring of 2008, ADA made the survey available over the Internet to secondary school students in Missouri's 524 school districts using the SmartTrack application. ADA continues to develop a systematic, data driven approach to identify statewide and regional prevention needs using data from this survey and other assessments. A final report of the Missouri's 2008 Student Survey will be published Fall 2008.

In FY 2007, Missouri had its Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan approved by the Center for Substance Abuse Prevention (CSAP). All 20 coalitions are now in the implementation phase of their projects. SPF SIG staff continue to provide training and technical assistance to the SPF SIG recipients to help them with implementation, strategic planning and evaluation. Missouri's priority under this grant is to reduce risky drinking for persons aged 12-25 years.

In December 2007, ADA published the fifth-year report of its SPIRIT initiative. The Missouri Institute of Mental Health has continued to provide program evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 3,938 students participated in the evaluation during FY 2008. The following measures continue to be used: Teacher Observation Checklist (K-3), SPIRIT Fidelity and Quality of Program Implementation Report, Healthy Kids Survey (grades 4-5), and the SPIRIT Survey (grades 6-12). Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age, and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

FY 2009 (Intended Use)

For treatment needs estimation, the Division of Alcohol and Drug Abuse (ADA) will continue to use a combination of data sources including, but not necessarily limited to, 1) the National Survey on Drug Use and Health (NSDUH) surveys and 2) Missouri's second State Treatment Needs Assessment Program (STNAP-II), conducted in 2000-2003 and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), under the CSAT Grant No. 5H79 TI12229. ADA anticipates that in 2009 SAMHSA will release state estimates from the combined 2006-2007 NSDUH. ADA will continue to seek improvements and/or establishment of additional benchmarks in its treatment needs estimations.

Updated estimates of treatment need will be used to calculate treatment penetration rates; plan and allocate treatment services; prepare presentation materials for the state legislature and other policy makers; and develop the ADA portion of the Department of Mental Health's annual budget request for SFY 2011. The estimates will also be summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm).

Funds have been allocated for program implementation under the Strategic Prevention Framework State Incentive Grant (SPF SIG). Sub-recipients funded through the SPF SIG will continue to work on their strategic plans in which they will assess needs, resources, and readiness at the community level as part of their planning process. The state's priority issue of risky drinking among young people ages 12-25 will be addressed through various evidence-based programs. National outcome measures specific to local prevention projects will continue to be collected at the community level. ADA will continue to plan for the biennial Missouri Student Survey which will next be conducted in the spring of 2008. The survey will be available online to all of Missouri's school districts. ADA will continue to collect data on the progress of students participating in the School-based Prevention and Intervention (SPIRIT) initiative.

Missouri
Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued the policy ensuring no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. ADA's contracts with treatment providers state: "The contractor agrees and understands that payments received under the contract SHALL NOT be expended in the following manner: to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection."

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2008 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continues the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators. During these reviews, all agencies were noted as compliant.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers will continue to be required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy will be ensured through the following: three-year Certification Survey's, Annual Safety and Basic Assurances Reviews and periodic site visits by the District Administrators and Area Treatment Coordinators.

Missouri
Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) utilized independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment and services provided. Seven independent peer reviews were conducted in FY 2006. The contracts for treatment providers required that they make staff available to perform peer reviews of other agencies in the state.

Peer Review Contract Language:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2008 (Progress)

The Division of Alcohol and Drug Abuse (ADA) facilitated seven peer reviews for FY 2008. Reviews are conducted in each region of the state and generally involve providers from different regions. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness and efficacy of the substance abuse treatment being provided. Peer reviews will be scheduled annually in each region of the state. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report will be distributed to the District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will review the report with the appropriate agency staff.

Missouri
Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2007 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency(SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review ;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures ;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

Attachment H

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment services provided. ADA has been contractually requiring all treatment providers to participate in independent peer review since July 1993. Contracted providers have been cooperating with this requirement each year since that time. Seven reviews were conducted in FY 2003, FY 2004, FY 2005, and FY 2006. Eight reviews were conducted in FY 2007.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

The agency being reviewed cooperates by providing access to consumer records, staff and policy and procedures documents. The reviewer utilizes this information to

establish the agency's compliance with certification standards, best practices and efficacy in operations. The reviewer has an opportunity to learn from another program's operations. The information is also useful to the ADA's treatment specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal confidentiality regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

In Summary, the role of ADA in Peer Reviews is as follows:

1. Providers are contractually bound to participate in Peer Reviews by ADA contracts;
2. The Area Treatment Coordinators initiate the Peer Review;
3. The Area Treatment Coordinators assure that the Peer Reviewer is a knowledgeable and experienced Substance Abuse Treatment Professional;
4. The Area Treatment Coordinators assure the findings and recommendations of the Peer Review visit are reported in a timely fashion;
5. The Area Treatment Coordinators review the findings and recommendations report;
6. The District Administrator reviews the findings and recommendations of the Peer Review report;
7. The District Administrator and Area Treatment Coordinator review the report with the appropriate audited agency staff and provide technical assistance.
8. The District Administrator reviews significant deviations from contractual requirements or Certification Standards with the Executive Director of the audited agency;
9. The District Administrator may review reoccurring problems with the ADA Division Director;
10. The District Administrator and Area Treatment Coordinator will utilize positive findings of innovative practices in technical assistance visits to all providers to spread improvements in clinical practice;
11. Copies of Peer Review findings and Recommendations are filed with the agencies certification file.

Missouri
Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitored the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurances Reviews and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2008 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. All new ADA employees receive orientation and training to division policy and the above sited confidentiality laws. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. ADA continues to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2009 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurances Reviews and periodic site visits by District Administrators and Area Treatment Coordinators.

Missouri
Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

FY 2006 (Compliance)

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Treatment and recovery support decisions are made with the participation of and in collaboration with consumers and treatment providers. All Consumers that qualify for ADA services and wish to receive recovery support services in a faith based program are provided with recovery support vouchers that allow for charitable choice and authorize services as a result of consumer-requested referrals to faith-based and non-traditional organizations.

Guidelines, training and technical assistance have been made accessible to providers. An application process to become an ATR provider was implemented which includes participation in the Addictions Academy (a 32-hour training program that integrates charitable choice requirements). Personnel designated specifically for this program perform oversight and audits of programs and services.

FY 2008 (Progress)

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract providers are required to follow the above procedures. There are 77 credentialed and contracted providers in Missouri listed on the Recovery Support System, of which 70 report that they are faith-based programs. Two programs are currently certified by ADA to provide clinical substance abuse treatment. Faith-based and nontraditional service organizations desiring to provide recovery support services must be credentialed by Committed Caring Faith Communities, an independent statewide not-for-profit 501(c) (3) interfaith corporation.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Treatment and recovery support decisions are made with the participation of and in collaboration with consumers and treatment providers. All Consumers that qualify for ADA services and wished to receive recovery support services in a faith based program are provided with recovery support vouchers that allow for charitable choice and authorize services as a result of consumer-requested referrals to faith-based and non-traditional organizations.

Guidelines, training and technical assistance have been made accessible to providers. An application process to become an Access to Recovery (ATR) provider was implemented which includes participation in the Addictions Academy (a 32-hour training program that integrates charitable choice requirements). Personnel designated specifically for this program perform oversight and audits of programs and services.

FY 2009 (Intended Use)

The Missouri Code of State Regulations will continue to require that individuals not be denied admission or receive services based on creed. The right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services will continue to require those agencies to comply with the Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

ADA will continue to develop resources that involves traditional, non-traditional and faith based organizations interested in providing recovery support services under the Access to Recovery (ATR) project. Recovery support providers will continue to allow charitable choice in substance abuse treatment services to consumers through the voucher process. Continuing training, certification and monitoring will ensure the consumers have charitable choice and quality services. In addition, an entire track for faith-based programs was added to the ADA's Spring Training Institute. Charitable Choice requirements were included in the curriculum of the classes in this track.

Data collection has been and remains a requirement of the ATR project. All data collected to meet these requirements and to conduct longitudinal outcome evaluation are being incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. ATR service providers are required to collect and enter this information into the CIMOR system.

State: Missouri

Attachment I: Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2008) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- [x] Used model notice provided in final regulations
- [ ] Used notice developed by State (Please attach a copy in Appendix A)
- [x] State has disseminated notice to religious organizations that are providers
- [x] State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- [ ] State has developed specific referral system for this requirement
- [x] State has incorporated this requirement into existing referral system(s)
- [x] SAMHSA's Treatment Facility Locator is used to help identify providers
- [x] Other networks and information systems are used to help identify providers
- [x] State maintains record of referrals made by religious organizations that are providers
- [x] 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

In FY 2008 Missouri was awarded $14.2 million over three years from the Access to Recovery II (ATR II) grant. The Division of Alcohol And Drug Abuse (ADA) will use the ATR II funds in four areas: 1) maintain a statewide voucher system for adults that affords genuine, free and independent choice among an increased number of qualified service providers; 2) provide recovery support services through traditional, non-traditional and faith-based organizations; 3) expand the existing managed care system for proper control and monitoring; and 4) measure outcomes in seven critical domains. Faith organizations and other nontraditional providers interested in providing recovery support services under the ATR II project are required to have a minimum of two staff or volunteers complete the Addictions Academy which includes Charitable Choice requirements. ADA included a Faith Based track at Spring Training Institute in FY 2007 and FY 2008 that included Charitable Choice provisions in several of the course curriculum offered.

State: Missouri

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128 (d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Missouri
Attachment J: Waivers

Attachment J: Waivers
If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Attachment J

Missouri is not requesting any waivers.

Form 4

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State: Missouri

Dates of State Expenditure Period: From: 7/1/2006 To: 6/30/2007

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2006 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 19,469,873	$ 24,583,667	$ 7,722,758	$ 29,915,319	$ 0	$ 35,430
Primary Prevention	$ 5,297,376		$ 2,730,579	$ 331,892	$ 0	$ 0
Tuberculosis Services	$ 11,039	$ 31,276	$ 2,667	$ 13,411	$ 0	$ 0
HIV Early Intervention Services	$ 0	$ 35,267	$ 1,543	$ 687,870	$ 0	$ 0
Administration: Excluding Program/Provider	$ 1,284,012		$ 2,660,282	$ 1,441,258	$ 0	$ 47,335
Column Total	**$26,062,300**	**$24,650,210**	**$13,117,829**	**$32,389,750**	**$0**	**$82,765**

***Prevention other than Primary Prevention**

Form 4ab

State: Missouri

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 740,099	$ 314,985	$ 10,488	$	$
Education	$ 2,244,930	$ 372,756	$ 1,076	$	$
Alternatives	$ 158,692	$ 84,247	$ 375	$	$
Problem Identification & Referral	$ 38,699	$ 0	$ 96	$	$
Community Based Process	$ 938,129	$ 305,027	$ 15,451	$	$
Environmental	$ 377,662	$ 384,058	$ 1,832	$	$
Other	$ 349,811	$ 1,269,686	$ 1,127	$	$
Section 1926 - Tobacco	$ 449,354	$	$ 301,447	$	$
Column Total	**$5,297,376**	**$2,730,759**	**$331,892**	**$0**	**$0**

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Universal Indirect	$ 1,081,032	$ 1,800,107	$ 331,892	$	$
Universal Direct	$ 2,356,216	$ 0	$ 0	$	$
Selective	$ 1,860,128	$ 930,652	$ 0	$	$
Indicated	$	$	$	$	$
Column Total	**$5,297,376**	**$2,730,759**	**$331,892**	**$0**	**$0**

Form4ab - Foot Notes

Other Federal: Safe & Drug Free Schools & Communities, Enforcing Underage Drinking Laws Block Grant (EUDL); DUDL Community Trails Initiative, Strategic Prevention Framework State Incentive Grant (SPF SIG)

State: Healthy Family Trust (State Tobacco Settlement funds) and General Revenue

Form 4c

Resource Development Expenditure Checklist

State: Missouri

Did your State fund resource development activities from the FY 2006 SAPT Block Grant?

(•) **Yes** ( ) **No**

Expenditures on Resource Development Activities are:

(•) **Actual** ( ) **Estimated**

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 204,542	$ 0	$ 204,542
Quality Assurance	$ 17,585	$ 0	$ 0	$ 17,585
Training (post-employment)	$ 12,879	$	$	$ 12,879
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 8,409	$ 297,678	$	$ 306,087
Research and Evaluation	$ 0	$ 265,966	$ 0	$ 265,966
Information Systems	$ 0	$ 0	$ 0	$ 0
Column Total	**$38,873**	**$768,186**	**$0**	**$807,059**

Form 6

SUBSTANCE ABUSE ENTITY INVENTORY

State: Missouri

				FISCAL YEAR 2006			
1. Entity Number	**2. I-SATS ID** [X] if no I-SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
008	X	Central Region	$566,698	$145,553	$0	$590,083	$0
009	MO901642	Eastern Region	$487,762	$0	$0	$0	$0
021	MO102084	Northwest Region	$389,858	$0	$0	$0	$0
037	MO750593	Southwest Region	$432,749	$399,819	$0	$0	$0
037a	MO100907	Southwest Region	$69,902	$64,583	$0	$0	$0
043	MO100948	Southwest Region	$101,191	$152,756	$0	$67,519	$0
043a	MO902004	Southwest Region	$23,994	$36,220	$0	$16,010	$0
045a	MO105244	Northwest Region	$67,455	$51,226	$0	$0	$0
045b	MO102142	Northwest Region	$229,889	$174,579	$0	$0	$0
045c	MO902608	Northwest Region	$39,542	$30,029	$0	$0	$0
045d	MO902673	Northwest Region	$43,032	$32,678	$0	$0	$0
048	MO101631	Southwest Region	$26,553	$1,940	$0	$0	$0
049a	MO106614	Central Region	$14,253	$11,064	$0	$878	$0
049b	MO106218	Southeast Region	$48,607	$37,731	$0	$2,994	$0
049c	MO103801	Southwest Region	$65,418	$50,780	$0	$4,030	$0
049d	MO106259	Southwest Region	$3,289	$2,553	$0	$203	$0
049e	MO901527	Southwest Region	$324,532	$251,916	$0	$19,990	$0
049g	MO106309	Southwest Region	$62,129	$48,227	$0	$3,827	$0
049h	MO103272	Northwest Region	$24,852	$19,291	$0	$1,531	$0
049i	MO106242	Southwest Region	$36,912	$28,653	$0	$2,274	$0
049j	MO100404	Southeast Region	$35,085	$27,234	$0	$2,161	$0
049k	MO103207	Central Region	$140,704	$109,220	$0	$8,667	$0
049l	MO105814	Central Region	$13,522	$10,496	$0	$833	$0
049m	MO103298	Central Region	$19,735	$15,319	$0	$1,216	$0
049n	MO105798	Central Region	$41,663	$32,341	$0	$2,566	$0
049o	MO103124	Northwest Region	$54,820	$42,553	$0	$3,377	$0
049p	MO103280	Northwest Region	$162,997	$126,522	$0	$10,040	$0
049q	MO901543	Northwest Region	$99,406	$77,163	$0	$6,123	$0
049r	MO103231	Northwest Region	$32,526	$25,248	$0	$2,004	$0
049s	MO103215	Northwest Region	$44,221	$34,326	$0	$2,724	$0
049t	MO100321	Central Region	$47,145	$36,596	$0	$2,904	$0
049u	MO100892	Southwest Region	$3,289	$2,553	$0	$203	$0

049v	MO106283	Central Region	$15,715	$12,199	$0	$968	$0
049w	MO103918	Southwest Region	$43,856	$34,043	$0	$2,701	$0
049x	MO100865	Northwest Region	$13,157	$10,213	$0	$810	$0
049y	MO106234	Northwest Region	$11,329	$8,794	$0	$698	$0
049z	MO100808	Northwest Region	$52,992	$41,135	$0	$3,264	$0
052a	MO103389	Southwest Region	$30,016	$15,382	$0	$0	$0
052d	MO901501	Southwest Region	$355,188	$182,016	$0	$0	$0
052e	MO100869	Southwest Region	$10,839	$5,554	$0	$0	$0
052f	MO100650	Southwest Region	$127,567	$65,372	$0	$0	$0
052g	MO100787	Southwest Region	$31,683	$16,236	$0	$0	$0
053a	MO102159	Central Region	$323,996	$320,886	$0	$0	$0
053b	MO750064	Central Region	$195,641	$193,763	$0	$0	$0
055a	MO903911	Southeast Region	$565,641	$112,361	$0	$0	$0
055aa	MO100774	Southeast Region	$18,365	$3,648	$0	$0	$0
055ab	MO105129	Southeast Region	$20,814	$4,134	$0	$0	$0
055b	MO103785	Southeast Region	$80,194	$15,930	$0	$0	$0
055c	MO104593	Southeast Region	$376,482	$74,786	$0	$0	$0
055d	MO100771	Southeast Region	$8,570	$1,702	$0	$0	$0
055e	MO100850	Southeast Region	$28,772	$5,715	$0	$0	$0
055f	MO100848	Southeast Region	$27,547	$5,472	$0	$0	$0
055g	MO104791	Southeast Region	$15,916	$3,162	$0	$0	$0
055h	MO100859	Southeast Region	$80,806	$16,052	$0	$0	$0
055i	MO105111	Southeast Region	$42,239	$8,391	$0	$0	$0
055j	MO100860	Southeast Region	$30,608	$6,080	$0	$0	$0
055k	MO100637	Southeast Region	$15,916	$3,162	$0	$0	$0
055l	MO100929	Southeast Region	$13,468	$2,675	$0	$0	$0
055m	MO100851	Southeast Region	$30,608	$6,080	$0	$0	$0
055n	MO104791	Southeast Region	$17,753	$3,526	$0	$0	$0
055o	MO100770	Southeast Region	$154,266	$30,644	$0	$0	$0
055p	MO100858	Eastern Region	$61,829	$12,282	$0	$0	$0
055q	MO100853	Southeast Region	$25,099	$4,986	$0	$0	$0
055r	MO000122	Southeast Region	$91,825	$18,240	$0	$0	$0
055s	MO100847	Central Region	$52,646	$10,458	$0	$0	$0
055t	MO101433	Eastern Region	$73,460	$14,592	$0	$0	$0
055u	MO105913	Southeast Region	$47,749	$9,485	$0	$0	$0
055v	MO100719	Southeast Region	$43,464	$8,634	$0	$0	$0
055w	MO100772	Southeast Region	$181,813	$36,116	$0	$0	$0
055x	MO100852	Southeast Region	$73,460	$14,592	$0	$0	$0
055y	MO100855	Southeast Region	$42,239	$8,391	$0	$0	$0
055z	MO100854	Southeast Region	$80,194	$15,930	$0	$0	$0
056a	MO101128	Southeast Region	$442,584	$217,075	$75,415	$42,700	$0
056ac	MO101227	Southeast Region	$161,669	$79,294	$27,548	$15,598	$0
056b	MO301793	Southeast Region	$901,221	$442,023	$153,564	$86,949	$0
056c	MO101391	Southeast Region	$19,492	$9,560	$3,321	$1,881	$0
056e	MO100620	Southeast Region	$12,613	$6,186	$2,149	$1,217	$0
056f	MO000041	Southeast Region	$147,910	$72,546	$25,203	$14,270	$0
056g	MO903598	Southeast Region	$16,052	$7,873	$2,735	$1,549	$0
056h	MO105640	Southeast Region	$55,036	$26,994	$9,378	$5,310	$0
057a	MO100872	Northwest Region	$384,508	$92,102	$103,796	$0	$0
057b	MO106010	Northwest Region	$244,333	$58,526	$65,956	$0	$0

057c	MO101094	Northwest Region	$677,513	$162,286	$182,891	$0	$0
058a	MO100518	Northwest Region	$259,708	$241,613	$120,348	$0	$0
058b	MO301678	Northwest Region	$616,660	$573,695	$285,758	$0	$0
058c	MO100914	Northwest Region	$48,331	$44,964	$22,397	$0	$0
061a	MO101011	Central Region	$276,525	$294,025	$63,933	$0	$0
061b	MO103694	Central Region	$10,898	$11,587	$2,520	$0	$0
061c	MO106101	Central Region	$43,136	$45,866	$9,973	$0	$0
061d	MO750098	Central Region	$467,685	$497,284	$108,130	$0	$0
061e	MO106671	Central Region	$68,564	$72,903	$15,852	$0	$0
061f	MO105830	Southeast Region	$8,173	$8,690	$1,890	$0	$0
061g	MO750502	Southeast Region	$322,839	$343,271	$74,641	$0	$0
061h	MO105848	Southeast Region	$11,352	$12,070	$2,625	$0	$0
061i	MO100718	Central Region	$23,157	$24,623	$5,354	$0	$0
062a	MO902269	Central Region	$292,268	$189,440	$116,213	$64,633	$0
062b	MO100179	Central Region	$255,171	$165,394	$101,462	$56,429	$0
062c	MO105475	Central Region	$30,580	$19,821	$12,159	$6,763	$0
062d	MO750056	Central Region	$40,607	$26,320	$16,146	$8,980	$0
062e	MO100187	Central Region	$231,108	$149,797	$91,894	$51,108	$0
062f	MO100785	Central Region	$12,032	$7,799	$4,784	$2,661	$0
062g	MO100784	Central Region	$7,018	$4,549	$2,791	$1,552	$0
062h	MO104262	Central Region	$15,040	$9,748	$5,980	$3,326	$0
062i	MO105285	Central Region	$25,066	$16,247	$9,967	$5,543	$0
062j	MO100776	Central Region	$54,142	$35,093	$21,528	$11,973	$0
062k	MO100483	Central Region	$16,042	$10,398	$6,379	$3,548	$0
062l	MO102159	Central Region	$57,652	$37,368	$22,924	$12,749	$0
062m	MO100782	Central Region	$6,517	$4,224	$2,591	$1,441	$0
062n	MO103207	Central Region	$33,588	$21,771	$13,356	$7,428	$0
062o	MO100783	Central Region	$9,525	$6,174	$3,787	$2,106	$0
074a	MO103330	Northwest Region	$3,456	$930	$0	$0	$0
074b	MO103348	Southwest Region	$1,868	$503	$0	$0	$0
074c	MO100930	Southwest Region	$13,825	$3,720	$0	$0	$0
082a	MO901592	Eastern Region	$513,094	$271,677	$0	$0	$0
082b	MO103009	Eastern Region	$145,189	$76,876	$0	$0	$0
082c	MO100503	Eastern Region	$57,794	$30,601	$0	$0	$0
082d	MO102209	Eastern Region	$163,513	$86,578	$0	$0	$0
087a	MO106598	Northwest Region	$92,034	$91,700	$0	$94,918	$0
087b	MO903127	Northwest Region	$242,993	$242,110	$0	$250,607	$0
089a	MO750403	Eastern Region	$235,756	$368,136	$0	$0	$0
090a	MO101136	Eastern Region	$768,304	$658,229	$213,851	$0	$0
090b	MO101458	Eastern Region	$232,634	$199,304	$64,752	$0	$0
090c	MO106069	Eastern Region	$80,606	$69,057	$22,436	$0	$0
090d	MO100381	Eastern Region	$139,274	$119,320	$38,766	$0	$0
090e	MO102803	Eastern Region	$116,827	$100,089	$32,518	$0	$0
090f	MO101037	Eastern Region	$7,652	$6,556	$2,130	$0	$0
090g	MO100765	Eastern Region	$352,012	$301,579	$97,978	$0	$0
090h	MO100581	Eastern Region	$33,161	$28,410	$9,230	$0	$0
090i	MO100786	Eastern Region	$47,445	$40,648	$13,206	$0	$0
152	X	Eastern Region	$6,920	$0	$0	$509,347	$0
153b	MO105723	Central Region	$81,910	$71,800	$0	$9,234	$0
153c	MO000024	Eastern Region	$452,214	$396,396	$0	$50,980	$0

153d	MO100567	Eastern Region	$493,738	$432,795	$0	$55,661	$0
153e	MO105715	Eastern Region	$189,418	$166,038	$0	$21,354	$0
153f	MO105046	Central Region	$122,297	$107,201	$0	$13,787	$0
153g	MO105780	Central Region	$53,469	$46,869	$0	$6,028	$0
153h	MO103942	Central Region	$58,020	$50,858	$0	$6,541	$0
153i	MO101797	Central Region	$4,551	$3,989	$0	$513	$0
153j	MO105038	Northwest Region	$94,993	$83,268	$0	$10,709	$0
153k	MO105210	Northwest Region	$94,993	$83,268	$0	$10,709	$0
153l	MO101169	Central Region	$434,580	$380,939	$0	$48,992	$0
153m	MO103892	Northwest Region	$50,625	$44,376	$0	$5,707	$0
153n	MO103900	Northwest Region	$272,466	$238,835	$0	$30,716	$0
153o	MO000025	Northwest Region	$191,124	$167,533	$0	$21,546	$0
153q	MO100668	Central Region	$329,348	$288,696	$0	$37,129	$0
153r	MO100884	Central Region	$7,964	$6,981	$0	$898	$0
153s	MO100281	Central Region	$37,542	$32,908	$0	$4,232	$0
153t	MO100768	Eastern Region	$285,549	$250,303	$0	$32,191	$0
153u	MO100623	Northwest Region	$141,637	$124,154	$0	$15,967	$0
153v	MO100714	Northwest Region	$77,360	$67,811	$0	$8,721	$0
153w	MO106093	Central Region	$19,909	$17,451	$0	$2,244	$0
154a	MO100526	Northwest Region	$240,940	$115,399	$0	$0	$0
154b	MO301785	Northwest Region	$643,022	$307,976	$0	$0	$0
154c	MO101441	Northwest Region	$404,656	$193,811	$0	$0	$0
154d	MO103678	Northwest Region	$5,148	$2,466	$0	$0	$0
154e	MO100882	Southwest Region	$4,119	$1,973	$0	$0	$0
154f	MO100878	Southwest Region	$12,871	$6,164	$0	$0	$0
154g	MO100615	Southwest Region	$153,934	$73,727	$0	$0	$0
154h	MO100881	Southwest Region	$30,375	$14,548	$0	$0	$0
154i	MO100875	Central Region	$7,722	$3,699	$0	$0	$0
154j	MO100877	Southwest Region	$3,604	$1,726	$0	$0	$0
154k	MO100870	Northwest Region	$112,748	$54,001	$0	$0	$0
154l	MO103900	Northwest Region	$5,663	$2,712	$0	$0	$0
154m	MO100874	Northwest Region	$4,119	$1,973	$0	$0	$0
154n	MO106762	Northwest Region	$11,841	$5,671	$0	$0	$0
156b	MO101029	Southwest Region	$352,267	$362,815	$385,961	$0	$0
156c	MO100287	Southwest Region	$49,441	$50,921	$54,170	$0	$0
158a	MO000022	Southeast Region	$190,375	$101,669	$0	$6,385	$0
158b	MO103157	Southeast Region	$34,672	$18,516	$0	$1,163	$0
158c	MO902319	Southeast Region	$293,106	$156,532	$0	$9,831	$0
158d	MO105095	Southeast Region	$80,901	$43,205	$0	$2,713	$0
158e	MO102571	Southeast Region	$87,322	$46,634	$0	$2,929	$0
158f	MO106705	Southeast Region	$160,197	$85,553	$0	$5,373	$0
158g	MO903853	Southeast Region	$319,752	$170,762	$0	$10,724	$0
158h	MO000021	Southeast Region	$103,053	$55,035	$0	$3,456	$0
158j	MO103165	Southeast Region	$24,720	$13,202	$0	$829	$0
158k	MO103140	Southeast Region	$61,318	$32,747	$0	$2,057	$0
158l	MO100928	Southeast Region	$6,421	$3,429	$0	$215	$0
158n	MO100730	Southeast Region	$65,812	$35,147	$0	$2,207	$0
171	X	Northwest Region	$6,171	$0	$0	$247,445	$0
173	MO903788	Eastern Region	$407,956	$342,154	$180,213	$0	$0
174	MO103967	Eastern Region	$112,104	$14,666	$0	$0	$0

175	MO903515	Southwest Region	$462	$102	$0	$0	$0
183	MO100716	Northwest Region	$0	$540,934	$0	$0	$0
185	MO101342	Northwest Region	$3,322	$0	$0	$95,076	$0
188a	MO100922	Southwest Region	$121,330	$198,459	$0	$0	$0
189	MO100591	Eastern Region	$422,702	$517,382	$570,521	$0	$0
201a	MO103587	Northwest Region	$919,600	$0	$0	$0	$0
201b	MO101433	Eastern Region	$303,209	$0	$0	$0	$0
207	MO101482	Southwest Region	$61,177	$8,074	$0	$0	$0
208	MO101490	Eastern Region	$191,165	$40,491	$0	$0	$0
209	X	Southwest Region	$77,362	$8,449	$0		$0
210a	MO101623	Eastern Region	$116,346	$10,687	$0	$0	$0
210b	MO103462	Eastern Region	$123,355	$11,331	$0	$0	$0
210c	MO106077	Eastern Region	$90,413	$8,305	$0	$0	$0
210d	MO103884	Eastern Region	$73,592	$6,760	$0	$0	$0
210e	MO100713	Eastern Region	$55,369	$5,086	$0	$0	$0
210f	MO100712	Eastern Region	$95,320	$8,756	$0	$0	$0
211	X	Central Region	$93,641	$6,144	$0	$0	$0
216	X	Northwest Region	$12,950	$5,115	$0	$0	$0
217	X	Northwest Region	$80,688	$5,550	$0	$0	$0
220	X	Central Region	$3,788	$0	$0	$0	$0
226	MO101755	Northwest Region	$99,551	$5,903	$0	$0	$0
227	X	Eastern Region	$41,330	$1,839	$0	$0	$0
231	X	Central Region	$100,309	$4,715	$0	$0	$0
238	MO102027	Eastern Region	$53,378	$8,472	$0	$0	$0
239	MO101987	Eastern Region	$36,665	$9,200	$0	$0	$0
249a	MO105434	Southeast Region	$13,156	$1,924	$0	$0	$0
249b	MO105442	Southeast Region	$5,481	$802	$0	$0	$0
249d	MO102035	Eastern Region	$440,712	$64,456	$0	$0	$0
249e	MO105459	Eastern Region	$35,082	$5,131	$0	$0	$0
249f	MO100738	Southeast Region	$7,674	$1,122	$0	$0	$0
249g	MO100739	Southeast Region	$9,319	$1,363	$0	$0	$0
250	MO102050	Northwest Region	$547,312	$52,845	$0	$0	$0
252	X	Southeast Region	$22,926	$87	$0	$0	$0
262	MO102928	Eastern Region	$858,053	$164,244	$0	$0	$0
264	X	Southwest Region	$34,674	$2,059	$0	$0	$0
267	X	Statewide (optional)	$0	$130,521	$0	$588,121	$0
269	MO105087	Eastern Region	$0	$441,616	$0	$0	$0
274	X	Southwest Region	$54,273	$4,680	$0	$0	$0
275	MO100711	Central Region	$84,030	$6,267	$0	$0	$0
276	MO100849	Southwest Region	$345,957	$292,176	$0	$0	$0
277	X	Southeast Region	$19,328	$2,485	$0	$0	$0
282	X	Northwest Region	$27,268	$3,396	$0	$0	$0
287	X	Central Region	$3,396	$0	$0	$0	$0
288	X	Southwest Region	$24,361	$2,874	$0	$0	$0
297	X	Northwest Region	$13,623		$0	$0	$0
311a	MO100623	Northwest Region	$0	$1,495	$0	$0	$0
312	MO100622	Southwest Region	$34,597	$16,714	$18,405	$0	$0
312a	MO903879	Southwest Region	$469,070	$226,609	$249,538	$0	$0
315	MO100687	Eastern Region	$41,985	$6,172	$0	$0	$0
315a	MO100688	Eastern Region	$49,263	$7,241	$0	$0	$0

316	X	Eastern Region	$10,784	$0	$0	$0	$0
318	MO100761	Eastern Region	$0	$553,381	$0	$0	$0
401	X	Statewide (optional)	$0	$5,189	$0	$0	$0
402	X	Statewide (optional)	$0	$3,220	$0	$0	$0
403	X	Statewide (optional)	$0	$19,168	$0	$0	$0
404	X	Statewide (optional)	$0	$25,476	$0	$0	$0
405	X	Statewide (optional)	$0	$8,349	$0	$491,041	$0
406	X	Eastern Region	$0	$0	$0	$27,500	$0
408	X	Southwest Region	$0	$0	$0	$186,643	$0
411	X	Eastern Region	$0	$0	$0	$68,855	$0
412	X	Eastern Region	$0	$0	$0	$103,222	$0
413	X	Statewide (optional)	$0	$0	$0	$125,000	$0
414	X	Southeast Region	$0	$0	$0	$119,000	$0
416	X	Northwest Region	$0	$0	$0	$177,203	$0
417	X	Southeast Region	$7,918	$0	$0	$76,698	$0
418	X	Southeast Region	$14,525	$0	$0	$68,681	$0
419	X	Northwest Region	$0	$0	$0	$1,193	$0
420	X	Southwest Region	$0	$0	$0	$253,965	$0
421	X	Statewide (optional)	$0	$0	$0	$20,324	$0
422	X	Northwest Region	$0	$0	$0	$153	$0
423	X	Statewide (optional)	$71,344	$0	$0	$0	$0
427	X	Southeast Region	$0	$0	$0	$176,631	$0
428	X	Southeast Region	$0	$0	$0	$3,700	$0
429	X	Southeast Region	$50,401	$261	$0	$0	$0
638	MO100667	Northwest Region	$156,774	$449,322	$0	$0	$0
Totals:			**$30,948,491**	**$19,480,911**	**$3,751,013**	**$5,297,376**	**$0**

PROVIDER ADDRESS TABLE

State: Missouri

Provider ID	Description	Provider Address
008	CENTRAL OFFICE	1706 E. Elm Street Jefferson City, MO 65101 573-751-4942
152	ST LOUIS AREA NATIONAL COUNCIL	8790 Manchester Road St. Louis, MO 63144 314-962-3456
171	NATIONAL COUNCIL OF GR KANSAS CITY	633 E. 63rd Street Kansas City, MO 64110 816-361-5900
209	SAFETY COUNCIL OF THE OZARKS	1111 South Glenstone Springfield, MO 65804 417-869-2121
211	MARTY ENTERPRISES (DBA AFFILIATED COURT SERVICES)	800 North Providence, Ste. 104 Columbia, MO 65203 573-499-3784
216	CAAREC	326 Cherry Street Chillocothe, MO 64601 660-646-1652
217	CENTRAL STATES MENTAL HEALTH CON	1132 Luttrell Suite F Blue Springs, MO 64015 816-224-4417
220	RASSE DAVID R & ASSOC	78 West Arrow St., PO Box 38 Marshall, MO 65340 660-886-3373
227	SAFETY COUNCIL OF GREATER STL	1015 Locust St., Ste. 902 St. Louis, MO 63101 314-621-9200
231	TRAFFIC SAFETY AWARENESS	747 N. State Highway 5 Camdenton, MO 65020 573-346-3829
252	ACCREDITED TRAFFIC OFFENDER SERV	1515 E. Malone Sikeston, MO 63801 573-471-7710
264	DOOR TO HOPE	1714 Camp Clark Hill Galena, MO 65656-0015
267	ACT MO	428 E. Capitol Avenue, Second Floor Jefferson City, MO 65101 573-635-6669
274	ALCOHOL DRUG CONSULTANTS	1736 East Sunshine, Ste. 214 Springfield, MO 65804 417-848-4565
277	HEARTLAND ALTERNATIVE SERVICE PROG	405 Poplar Street Poplar Bluff, MO 63901 573-686-5488
282	ST JOSEPH SAFETY & HEALTH COUNCIL	118 South Fifth Street (Lower Level) St. Joseph, MO 64501-2130 816-233-3330
287	DEAF HOPE	PO BOX 14441 Shawnee Mission, KS 66215 913-621-4673
288	SOUTH CENTRAL MO CITIZEN'S ADVISORY	1559 Imperial Center West Plains, MO 65775 417-257-7568
297	ABOUT FACE COMMUNITY COUNSELING	6301 Rockhill Road, Suite 105 Kansas City, MO 64131 816-444-6200
		514 Jefferson Street

316	JONES TIMOTHY MA INC	Washington, MO 63090 636-239-2054
401	COMMUNITY HOUSING NETWORK	2600 East 12th Street Kansas City, MO 64127 816-482-5744
402	COVINGTON AND BURLING	1201 Pennsylvania Ave, NW Washington, DC 20044 202-662-5410
403	OXFORD HOUSE	1010 Wayne Avenue, Ste. 300 Silver Spring, MD 20910 301-587-2916
404	UNIVERSITY OF MO - KC	5100 Rockhill Road Kansas City, MO 64110 816-235-2647
405	UNIVERSITY OF MO - COLUMBIA	Sponsored Programs Admin 310 Jesse Hall Columbia, MO 65211 573-882-9587
406	BIG BROTHERS BIG SISTERS	501 North Grand St. Louis, MO 63103 314-361-5900
408	COMMUNITY PARTNERSHIP OF OZARKS	330 N. Jefferson Springfield, MO 65806 417-888-2020
411	DISCOVERING OPTIONS	909 Purdue Avenue St. Louis, MO 63130 314-721-8116
412	FRIENDS WITH A BETTER PLAN	5622 Delmar Suite 102E St. Louis, MO 63112 314-361-2371
413	LEAD INSTITUTE	311 Bernadette Drive, Ste. C Columbia, MO 65203 573-817-2400
414	LINCOLN UNIVERSITY	Business & Finance, 306 Young Hall Jefferson City, MO 65102 573-681-5058
416	MO ALLIANCE OF BOYS/GIRLS CLUB	6301 Rockhill Road, Ste. 303 Springfield, MO 64131 816-361-3600
417	PREVENTION CONSULTANTS OF MO	104 East 7th Street Rolla, MO 65401 573-368-4755
418	SOUTHEAST MO STATE UNIVERSITY	One University Plaza Cape Girardeau, MO 63701 573-651-2196
419	ST JOSEPH POLICE DEPARTMENT	501 Faraon St. Joseph, MO 64501 816-271-4701
420	UNITED WAY OF THE OZARKS	320 N. Jefferson Springfield, MO 65806-1109 417-863-7700
421	UNIVERSITY OF OKLAHOMA	Office of Proj & Compl Ass. 660 Parrington Oval 324 Norman, OK 73019 918-660-3700
422	CITY OF INDEPENDENCE POLICE CHIEF	223 N. Memorial Drive Independence, MO 64050 816-325-7291
423	SAVE	PO Box 45301 Kansas City, MO 64171 816-531-8340
427	MISSISSIPPI CO CIRCUIT COURT	PO Box 369 Charleston, MO 63834
428	COUNTY OF ST. FRANCOIS HEALTH	1025 West Main Street Park Hills, MO 63601 573-431-1947
429	TERRY RAMSEY COLE INC	1515 E. Malone Sikeston, MO 63801

		573-471-7710

Form 6a

State: Missouri

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	8
	Mentors [15]	3
	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	1
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	8
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Mentors [15]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Drop-Outs [3]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	1
	Information lines/Hot lines [8]	1
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Community service activities [24]	12
	Recreation activities [26]	5
	Student Assistance Programs [32]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
Violent and Delinquent Behavior [4]	Ongoing classroom and/or small group sessions [12]	8

	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Mentors [15]	3
	Community service activities [24]	12
	Recreation activities [26]	5
	Driving while under the influence/driving while intoxicated education programs [33]	12
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Accessing services and funding [45]	12
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	1
	Brochures [4]	22
	Speaking engagements [6]	12
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	8
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Economically Disadvantaged [6]	Resources directories [2]	16
	Media campaigns [3]	1
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	8
	Education programs for youth groups [14]	8
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5

	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Systematic planning [42]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Physically Disabled [7]	Clearinghouse/information resources centers [1]	3
	Brochures [4]	2
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	1
	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Abuse Victims [8]	Clearinghouse/information resources centers [1]	3
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	8
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Already Using Substances [9]	Resources directories [2]	16
	Media campaigns [3]	1
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	8
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	8
	Mentors [15]	5

	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Community service activities [24]	2
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	16
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Brochures [4]	22
	Information lines/Hot lines [8]	1

Form 7a

TREATMENT UTILIZATION MATRIX

State: Missouri

Dates of State Expenditure Period: From: 7/1/2006 To: 6/30/2007

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A.Number of Admissions**	**B.Number of Persons**	**C.Mean Cost of Services per Person**	**D.Median Cost of Services per Person**	**E.Standard Deviation of Cost per Person**
Detoxification (24-Hour Care)					
Hospital Inpatient (Detox)	0	0	$ 0	$ 0	$ 0
Free-standing Residential	8420	5915	$ 338.54	$ 257.22	$ 306.91
Rehabilitation / Residential					
Hospital Inpatient (Rehabilitation)	0	0	$ 0	$ 0	$ 0
Short-term (up to 30 days)	10731	8582	$ 298.07	$ 308.40	$ 186
Long-term (over 30 days)	0	0	$ 0	$ 0	$ 0
Ambulatory (Outpatient)					
Outpatient	25781	21280	$ 1066.19	$ 755.05	$ 1055.37
Intensive Outpatient	13996	11373	$ 3050.11	$ 1992.98	$ 3292
Detoxification	0	0	$ 0	$ 0	$ 0
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	380	339	$ 1560.51	$ 1286.57	$ 1052.60

Form 7b

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

State: Missouri

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	3886	1663	1042	655	297	2	0	2	1	6	4	58	23	76	57	2387	1368	75	56
2. 18-24	7299	3967	1706	1043	291	0	1	6	4	20	5	94	48	82	32	5103	2052	109	35
3. 25-44	19730	9664	4736	3329	1420	2	2	24	13	41	17	165	88	175	54	13140	6233	260	97
4. 45-64	7012	3426	1196	1692	536	0	0	4	2	15	3	53	29	47	9	5154	1760	83	15
5. 65 and over	142	87	16	33	4	0	0	0	0	1	0	0	1	0	0	119	21	2	0
6. Total	38069	18807	8696	6752	2548	4	3	36	20	83	29	370	189	380	152	25903	11434	529	203
7. Pregnant Women	437		311		105		1		3		3		6		8		427		10

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? (•) Yes ( ) No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 9835

- Foot Notes

In FY 2007, another 4,122 persons were served with recovery support services in lieu of clinical treatment. These cases are not reportable to TEDS.

Missouri
Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

TB SERVICES

The Department of Mental Health (DMH) - Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections (DOC), Missouri Department of Health and Senior Services (DHSS), and the Missouri Department of Social Services (DSS) - MO HealthNet Division (Medicaid) to collect the information required to report the statewide non-federal cost of Tuberculosis (TB) Services provided to citizens of Missouri including substance abusers in treatment. The statewide expenditures for TB Services to substance abusers in treatment have been calculated with the following methodology.

DMH-ADA gathers TB cost data from the other state agencies. DOC provides aggregated costs of TB services to inmates in correctional facilities and associated costs to those inmates in institutional substance abuse treatment programs. DHSS provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs. DSS provides statewide Medicaid expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. State Medicaid expenditures for TB services provided by ADA funded programs are a subset of the information received from DSS and represent the percent of Medicaid TB expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from DMH-ADA non-Medicaid expenditure data. For expenditures prior to October 6, 2006, TB data was obtained from the department's POS system. For expenditures after October 6, 2006, TB data was obtained from the department's new information system, Customer Information Management, Outcomes & Reporting (CIMOR) which also captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds) per the two data systems.

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

ADA used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children. POS and CIMOR systems capture services delivered to clients by service code. For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The total expenditures on these qualified programs were $9,362,319 for FFY2007 and projected to be $9,135,883 for FFY2008. These amounts are greater than the required base expenditures of $7,728,020.

SSA (MOE TABLE I)

State: Missouri

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2006) + B2(2007) ---------- 2 (C)
SFY 2006 (1)	**$38,485,680**	**$40,140,229**
SFY 2007 (2)	**$41,794,777**	
SFY 2008 (3)	$ 44,995,529	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2006 (•) Yes ( ) No

FY 2007 (•) Yes ( ) No

FY 2008 (•) Yes ( ) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2008 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

(•) Yes ( ) No If yes, specify the amount and the State fiscal year: $ 286477 , 2008(SFY)

Did the State include these funds in previous year MOE calculations?

( ) Yes (•) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date) 8/29/2008

TB (MOE TABLE II)

State: Missouri

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	**$ 421,670**	**0.06 %**	**$ 253**	**$ 1,265**
SFY 1992 (2)	**$ 455,117**	**0.50 %**	**$ 2,276**	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2008 (3)	**$ 719,199**	**7.117360 %**	**$ 51,188**

HIV (MOE TABLE III)

State: Missouri

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 -------- 2 (B)
SFY 1993 (1)	$ 298,242	$ 301,434
SFY 1994 (2)	$ 304,625	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2008 (3)	$

* Provided to substance abusers at the site at which they receive substance abuse treatment

- Foot Notes

Missouri is not a designated state.

Womens (MOE TABLE IV)

State: Missouri

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$7,728,020**	
2006		**$9,011,586**
2007		**$9,362,319**
2008		$ 9,135,883

Enter the amount the State plans to expend in FY 2009 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 9,409,959

Missouri
1. Planning

1. Planning
This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F.R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of **up to three pages**, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F.R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2009 application for SAPT Block Grant funds.

Substate Area Planning

The Missouri Department of Mental Health has five planning regions that are used by its Division of Alcohol and Drug Abuse (ADA) and Division of Comprehensive Psychiatric Services (CPS). The ADA planning regions are further divided into 20 service areas consisting of clusters of counties. The largest metropolitan service areas comprise one or two counties while some of the rural service areas cover up to nine counties. In June 2000, ADA completed a planning and decision model and issued a report titled "Placement of Expanded Treatment Services". The model prescribes a methodology to 1) rank treatment need based on substance abuse indicators, 2) identify service gaps, and 3) prioritize expansion of an array of youth and adult services in each service area. The methodology was used several times to add new sites for CSTAR services for women and general adult populations. Data from the 2003 State Treatment Needs Assessment Program (STNAP-II) were applied to the model when it was last used for program placement decision-making.

The availability of state data from the National Survey on Drug Use and Health (NSDUH)—particularly the sub-state estimates for the ADA regions and some of the service areas—provides new opportunities to improve planning. ADA is developing a monitoring process that will help gauge the accessibility of services for the populations needing substance abuse treatment. This process will quantify treatment need based on the NSDUH sub-state estimates for alcohol dependence and abuse, illicit drug dependence and abuse, and needing but not receiving treatment for alcohol abuse and illicit drug abuse by age group. ADA will supplement and refine these estimates with county-level and service area-level analysis of alcohol related and drug related emergency department episodes and traffic crashes. In recent years, most of this data have been reported to ADA in two age groups (up to age 25 and older than 25, affording some compatibility with the NSDUH data. In future years, ADA will try to access this data disaggregated by gender to develop a definitive set of population groups for analysis. Treatment utilization information is the other important component of the monitoring system. ADA will analyze alcohol and drug abuse admissions recorded in the Customer Information, Management, Outcomes, and Reporting (CIMOR) system. Eventual implementation of address geo-coding in CIMOR should streamline the use of GIS to identify customers' average distances from their residences to their treatment programs. The monitoring process will provide more specificity and precision in assessing availability and accessibility of services. This information should be valuable to treatment providers who intend to relocate or expand services and to ADA administrators who must determine whether such changes are in the best interests of the population needing treatment.

Prevention planning and identification of highest need are ongoing processes. Data collection has evolved from solely qualitative community-based information to more comprehensive methods. The process has expanded the Center for Substance Abuse Prevention (CSAP) Needs Assessment Studies and has incorporated new data from other resources. The Missouri Student Survey has been utilized at the local level by coalitions for identifying needs and requesting DMH funding for local level mini-grants

and other federal and private sources of funding for strategies and programming. Information for risk and prevalence data is captured through both qualitative and quantitative methods. Additionally, as a pilot state for CSAP's Management Information System (MIS) project, ADA's service providers are required to input service process information into the Minimum Data Set (MDS). The MDS collects service type, target audience, aggregate demographics of participants, and risk factors. Since the initial replication of the Missouri Student Survey in 2002, subsequent prevention initiatives have used a variety of methods and different levels of substate data collection. ADA initiatives and programs have provided the following information: specific K-12 school data and research-based program monitoring of the School-based Prevention and Intervention Resources Initiative (SPIRIT); training needs of the prevention workforce; and binge drinking rates among college students from the Core survey and the Missouri College Health Behavior Survey.

The one-year CSAP State Incentive Planning Grant and the five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) are making a significant contribution to planning through the formation of the Governor's Substance Abuse Prevention Initiative Advisory Committee. The Governor's Substance Abuse Prevention Initiative Advisory Committee serves as an advisory body to ADA. With representation from state agencies impacted by substance abuse, other stakeholders, the State Advisory Council (SAC), and service providers--and with technical support from its subcommittees and the State Epidemiological Workgroup--the Advisory Committee has an important role in making recommendations to ADA. Building on the work and information from the CSAP Prevention Needs Assessment Studies completed in the early part of the decade, the Advisory Committee and its workgroups have completed or are currently developing several projects. They conducted Hispanic and Asian focus groups in each of the state's planning regions, piloted the Tri-Ethnic Institute's Community Readiness Assessment, developed an inventory of prevention resources and activities, and prepared a prevention needs assessment report. The Prevention Workforce Development Task Force was created in order to assess workforce activities and training needs and make recommendations regarding standardized training and multi-tier certification program. The Missouri Substance Abuse Professional Credentialing Board now offers three levels of prevention credentials.

As a requirement of the SPF SIG, a State Epidemiology Workgroup (SEW) was established in April 2005. Membership of the SEW consists primarily of data managers and researchers in government agencies that address substance abuse problems. These include the U.S. Drug Enforcement Administration, Missouri State Highway Patrol, Missouri Department of Health and Senior Services, Missouri Department of Corrections, Missouri Department of Social Services, Missouri Department of Mental Health, St. Louis Mental Health Board, and St. Louis Community Epidemiology Work Group. The SEW assembled and compared rates of Missouri and national substance abuse consumption and consequences data, including all data sets contained in the State Epidemiology Data System (SEDS). The SEW also used county-level Missouri data in a geographic information system to map the number of occurrences, and population-based rates of a variety of substance abuse consequences. These included

alcohol and drug related traffic crashes, arrests, emergency room episodes, juvenile court referrals, out-of-home placements, and births compromised by maternal substance abuse. This data analysis, recommendations, and a comprehensive *SPF SIG Initial Needs Assessment* report developed by project staff at the Missouri Institute of Mental Health were presented to the Governor's Advisory Committee. The Advisory Committee considered several substance abuse problems identified as priority issues and adopted a state prevention plan that addresses risky drinking behavior, particularly underage and binge alcohol use in the 12-25 age group. The SPF SIG Strategic Plan was submitted to CSAP in 2006 and approved for implementation. In the fall of 2006, six-month planning grants—with potentially two and one-half years of prevention program implementation funding—were awarded to 18 community coalitions. Consistent and comprehensive county-level data on underage and binge alcohol use were not available to support the coalitions in their planning processes. Therefore, the SEW identified the need to 1) provide technical assistance to the coalitions to collect local data and 2) facilitate statewide systemic efforts to increase the availability of localized alcohol consumption data. The SEW has been working with officials to access--and conduct additional analysis on--Missouri data from the Behavioral Risk Factor Surveillance System (BRFSS). Aside from its role in planning, data will be used to measure the effectiveness of the funded projects in reducing rates of risky drinking. The SEW continues to monitor and compare national and state data from the BRFSS, the NSDUH, and the Youth Risk Behavior Survey--and county-level substance abuse indicators--to support ongoing project planning, feedback to funded coalitions, and data-driven outcome evaluation.

Technological advances are also part of the evolving system. ADA strives to achieve more effective and efficient ways to identify areas and populations with highest incidence, prevalence, risk factors, and need for prevention and treatment services. Such progress is evident with the improvements made in capturing student information. In 2000, the first Missouri Student Survey was administered to a random sample of 12,600 students in 254 schools. In 2002, the survey was replicated using state specific lessons learned and a larger sample. The 2004 Missouri Student Survey was the first to be administered over the Internet using the SmartTrack application and was made available to all of Missouri's 524 school districts. Although not all districts were able to participate, approximately 60,000 students in grades 6–12 responded to the survey. The number of respondents increased to almost 70,000 in 2006, and is expected to reach 120,000 in 2008, the largest survey of its type in the state.

Planning culminates with its integration into the state budgeting process. Treatment and prevention program performance and outcome measures are described and quantified in the annual budget requests of the Department of Mental Health and its divisions, including ADA. Measured performance is annually compared with projections, and new or revised decision items with plan components are developed to address emerging needs. During the processes of prioritizing and justifying these proposed programs and services, additional plan details such as consumer eligibility, treatment methods, program locations, and management issues are clarified and elaborated.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. According to statute, the SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current technologies and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system, and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The SAC, as well as the general public, has an opportunity and is encouraged to provide input and feedback on the Substance Abuse Prevention and Treatment (SAPT) Block Grant applications. The SAC is notified when these applications are posted on the ADA block grant website at: http://www.dmh.missouri.gov/ada/blockgrant.htm.

The SAC consults with ADA's District Administrators, Area Treatment Coordinators, and Prevention Specialists. The Treatment Coordinators monitor the ADA-funded treatment programs and their utilization rates and refer prospective consumers to programs which are the most appropriate, accessible, and available. The Prevention Specialists monitor ADA-funded prevention programs and provide consultation on appropriate strategies. The District Administrators gather input from their staff, the advisory council members, and other sources to develop a thorough understanding of the service gaps in their districts with regard to locations, types of services, and populations to be served. The ADA Executive Staff utilize data from the needs assessment models, data analysis conducted by the ADA Research and Statistics unit, and consult with the District Administrators on decisions involving program expansions and reallocations. Information from these multiple sources helps ensure that ADA expends its funds to provide services in communities and for populations with the greatest needs.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed--and how--to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The SAC has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. Most SAC members have leadership roles as managers, advocates or volunteers in the substance abuse service delivery system. The SAC meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning, performance measurement development, and other aspects of service delivery system. The SAC chairperson appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. SAC members continually seek input from individuals, agencies, and organizations impacted by substance abuse.

The content of the SAPT block grant application's state plan reflects recommendations originating from the SAC and other sources, including direct citizen input. The compressed time frame for preparing the SAPT application precludes a review by the SAC prior to its submission to the Center for Substance Abuse Treatment (CSAT). To facilitate ongoing review, each application is posted to the ADA block grant website at http://www.dmh.missouri.gov/ada/blockgrant.htm. The array of links to current and past block grant applications is preceded by a narrative that explains the purpose of the block grant. It states (in part) the following: "The SAPT block Grant Application is prepared and submitted annually to the Center for Substance Abuse Treatment (CSAT) by the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (ADA). The application is a requirement for receiving Missouri's portion of the SAPT block Grant, a major source of ADA funding. The SAPT application includes a state plan that describes how SAPT funds will be used. The CSAT requires each state to have a process to facilitate public comment in developing the plan and the application for Block Grant funds. The Division encourages interested persons to review the application and submit comments and suggestions that can be considered for inclusion in the next Block Grant application submission. Please provide your input by writing to: Director, Division of Alcohol and Drug Abuse; P.O. Box 687; Jefferson City, MO 65102. Or you can e-mail your comments and suggestions to: adamail@dmh.mo.gov." ADA notifies the SAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's

central and district office staff for consideration in developing the next application. This process provides ongoing access to the SAPT applications and feedback from the advisory network and general public.

Planning Checklist

State: Missouri

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2009 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:

2006 population estimates of service areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specify method)

maintenance of existing services

2 Size of gaps between resources (as measured by)

number of consumers served in FY 2008

and needs (as estimated by)

updated prevalence estimates based on the Missouri 2005/2006 NSDUH

Other (specify method)

Form 8

State: Missouri

Treatment Needs Assessment Summary Matrix

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northwest Region	1413384	115696	11583	3127	1245	43000	3518	10691	13988	43	6	14	2

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Central Region	772176	65037	5774	1686	511	29000	3103	6399	5272	689	3	4	1

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Eastern Region	2082754	177113	21088	4601	1684	76000	8009	10355	14368	39	4	13	2

Calendar Year: 2006

1. Substate Planning	2. Total Population	3. Total Population	4. Number of IVDUs	5. Number of women in need	6. Prevalence of substance-	7. Incidence of communicable diseases

Area		in need		in need				related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southwest Region	880216	66635	5555	2010	205	23000	584	6318	5816	64	3	6	2

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southeast Region	694183	52516	2864	1550	162	19000	802	6046	6370	12	4	1	1

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	5842713	477000	46863	12751	3675	190000	15959	39809	45814	847	4	9	2

Form 9

State: Missouri

Substate Planning Area [95]: State Total

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	42,998	25,638	10,702	3,902	1,564	9	0	19	8	38	24	282	100	447	265	29,418	12,200	917	463
18 - 24 Years Old	127,364	63,657	43,983	9,412	6,427	7	13	94	127	203	76	836	721	1,112	696	73,601	50,924	1,720	1,117
25 - 44 Years Old	196,590	98,261	67,891	15,646	11,133	17	10	161	112	198	132	691	554	1,293	491	113,744	78,969	2,521	1,362
45 - 64 Years Old	83,706	41,838	28,907	7,103	4,939	0	0	30	15	86	45	175	181	271	116	48,684	33,866	820	338
65 and Over	26,325	13,158	9,091	2,315	1,527	0	0	32	0	32	69	0	69	32	0	15,450	10,757	119	0
Total	476,983	242,552	160,574	38,378	25,590	33	23	336	262	557	346	1,984	1,625	3,155	1,568	280,897	186,716	6,097	3,280

- Foot Notes

Totals may not equal due to rounding.

Missouri

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

How your State determined the numbers for the matrix

Form 8:

Column 1: Substate planning area
The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as service areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population
The population of each sub-state region listed on Form 8 is based on the 2006 population estimates prepared by the U.S. Census Bureau and the Missouri Census Data Center.

Column 3: Total population in need
The estimate for total population in need (477,000) was obtained from the National Survey on Drug Use and Health (NSDUH) 2005-2006. Treatment need is based on the percentage estimates of "alcohol or illicit drug dependence or abuse within the past year". The substate rates were obtained from the NSDUH 2004-2006 and applied to the 2005 population age 12 and over for each planning area. This distribution among substate planning areas was then used to allocate the current 477,000 total in need. This represents a change in methodology since previous Substance Abuse Prevention and Treatment Block Grant applications whereby the State based substate population estimates on the results from the Missouri State Treatment Needs Assessment Program (STNAP-II) study, conducted in 2000-2003. The primary reason for changing the methodology in favor of the NSDUH substate data is that STNAP-II tends to under-estimate the need in Northwest Region, in particular Jackson County. According to STNAP-II, the need in Northwest Region accounts for 17% of the State's need. In comparison, the NSDUH data indicates that this need represents 24% of the State's need.

For the number seeking but not receiving treatment, the State has no other feasible data source other than the STNAP-II data. The STNAP-II study estimates that 16% of household consumers would seek treatment and 50% of non-household residents would seek treatment. Therefore a rate of 20% was used to determine the number of consumers who would seek treatment. In FY 2007, ADA provided substance abuse treatment services to 55,028 Missouri residents whose county of residence (and therefore ADA planning region) are known. By subtracting the residents who accessed treatment services from the 95,400 who would seek treatment, an estimated 40,372 residents who would seek substance abuse treatment did not receive services in FY 2007. This unmet demand is reported by planning region in column 3B.

The State did survey how other states are determining their seeking treatment data via an online search of SAPT Block Grant applications posted on states' public websites. Of ten states surveyed, three reported their rates of seeking treatment based on their state treatment needs assessment. These rates ranged from 9.88% to 13.56% which compares fairly well with Missouri's rate of 8.4% (20% seeking less 11.5% served). Other states used an educated guess to determine their seeking treatment data and one based their rate on the state's waiting list data. Educated guesses ranged from 10% to 30%. One state did not report seeking treatment data.

Column 4: Number of IVDUs in need

The State continued to use population-adjusted STNAP-II estimates for the number of intravenous drug users (IVDU) in need. According to the STNAP-II data, 2.5% of those needing treatment are IVDU's.

Although the STNAP-II study did not estimate the number of IVDU who would seek treatment, it did estimate that 50% of high-risk non-household adults would seek treatment. During the last four years, ADA has actually provided services to more than 50% of the estimated IVDU in some of the planning regions, so a potential treatment seeking rate of 60% of prevalence was applied to the IVDU to yield an estimated 7,650 IVDU that would seek treatment. Subtracting the 3,975 IVDU whose county of residence (and therefore ADA planning region) are known and who received treatment services in FY 2007 from the 7,650 who would seek services, an estimated 3,675 IVDU who would seek treatment did not receive services in FY 2007. This unmet demand is reported by planning region in column 4B.

IVDU data is problematic for most other states surveyed. For seeking treatment, states are either applying the same rate obtained for the total population seeking treatment or are applying an educated guess. Rates range from 10% to 36% which is comparable to Missouri's rate of seeking but not receiving (28%) – that is, 60% of needing less 31% needing and served.

The State inquired into getting IVDU data from the NSDUH data but the small number of IVDU's encountered in the household phone survey makes estimates on the substate level impossible and even difficult on the state level. Missouri will continue to explore other sources for obtaining IVDU data in an effort to improve estimates.

Column 5: Number of women in need

In August 2008, the State submitted a data request through the State's Center for Substance Abuse Treatment (CSAT) project officer to get percentage estimates of women dependent on or abusing alcohol or illicit drugs in the past year based on 2002-2007 NSDUH data. This data was provided by CSAT in time to incorporate into the State's needs assessment for the FY 2009 Block Grant application. In prior years, ADA used estimates from the STNAP-II study. The NSDUH data puts the estimate of women needing treatment at 190,000 – which was used in form 8 and form 9. The Division was particularly grateful to CSAT for providing this data as ADA is seeking, through a new budget item, an expansion of the Women's program in under-served areas.

In determining the number of women seeking treatment, ADA applied the STNAP-II rate of women seeking treatment – roughly 17.5%. In FY 2007, ADA provided substance abuse treatment services to 17,130 Missouri women whose county of residence (and therefore ADA planning region) are known. By subtracting the women who accessed treatment services from the 33,089 who would seek treatment, an estimated 15,959 women have an unmet demand for treatment. This unmet demand is reported by planning region in column 5B.

Limitation of Data in Columns 3, 4, and 5

The STNAP-II study was conducted from 2000 to 2003. The household telephone interviews, which provided much of the core data for the prevalence estimates, were administered in 2001 and 2002, so much of the data is six years old or older. Although the aggregate treatment need of 491,224 identified by the STNAP-II is very close to the estimate of 477,000 with alcohol or illicit drug dependence or abuse derived from the 2004-2006 NSDUH, components of the NSDUH estimates are very different. STNAP-II estimated that 39,000 adolescents needed substance abuse treatment or intervention, including 29,378 who needed treatment. OAS estimated that 43,000 adolescents have alcohol or illicit drug dependence or abuse. There were also variances in the other age groups between the STNAP-II treatment need estimates and the dependence and abuse estimates from the NSDUH.

ADA will review the latest NSDUH estimates for Missouri and its planning regions as they become available and will integrate these survey results into the Missouri prevalence estimates. The substate data should provide more clarification on the geographic distribution of Missouri's population in need of substance abuse treatment services.

Column 6: Prevalence of substance-related criminal activity

Driving while intoxicated (DWI) arrests, drug arrests, and operating vessel under the influence" (OVUI) arrests are included in the Uniform Crime Reporting system. Data is coded according to the county of arrest and aggregated to the ADA planning regions. OVUI was selected for reporting in the optional column because Missouri has a large number of lakes and navigable streams that are used for boating, skiing, canoeing, and other water recreation. Alcohol-related boat crashes, drowning, and injuries are a significant problem in the state.

Column 7: Incidence of communicable diseases

The 2006 data on acute and chronic hepatitis B, HIV&AIDS, and tuberculosis disease were provided by the Missouri Department of Health and Senior Services. The data are aggregated to the ADA planning regions using the county of residence at time of diagnosis. The rates are based on the number of cases per 100,000 residents in accordance with 2006 population estimates.

Form 9:

The total number of youth age 12-17 with dependent on or abuse of alcohol or any illicit drug (43,000) was obtained from the 2002-2004 NSDUH. The total was distributed among the white male, white female, other male, and other female cohorts according to the STNAP-II rates. The total in need for female (190,000) was distributed among the white female (84.5%) and other female (15.5%) cohorts using the STNAP-II rates. The total for male (477,000 – 190,000 = 287,000) was done similarly. The difference between the totals for these cohorts and the calculations for the 12-17 age groups was then distributed according to STNAP-II age rates: 18-24 (29.35%), 25-44 (45.37%), 45-64 (19.29%), and 65 and over (6%). The groups "other male" and "other female" were used to further synthesize specific non-white race groups by applying rates of FY 2007 treatment admissions. The groups for non-Hispanic and Hispanic were generated by treatment rates as well.

Form 11

State: Missouri

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2009 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 19,540,126	$ 49,167,334	$ 15,445,516	$ 59,830,638	$ 0	$ 144,570
Primary Prevention	$ 5,213,644		$ 5,461,518	$ 663,784	$ 0	$ 0
Tuberculosis Services	$ 11,039	$ 62,552	$ 5,334	$ 26,822	$ 0	$ 0
HIV Early Intervention Services	$ 0	$ 70,534	$ 3,086	$ 1,375,740	$ 0	$ 0
Administration: (Excluding Program/Provider Lvl)	$ 1,303,411		$ 5,320,564	$ 2,882,516	$ 0	$ 132,665
Column Total	**$26,068,220**	**$49,300,420**	**$26,236,018**	**$64,779,500**	**$0**	**$277,235**

Form 11ab

State: Missouri

Form 11a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 728,401	$ 629,970	$ 20,976	$ 0	$ 0
Education	$ 2,209,446	$ 745,512	$ 2,152	$ 0	$ 0
Alternatives	$ 156,184	$ 168,494	$ 750	$ 0	$ 0
Problem Identification & Referral	$ 38,087	$ 0	$ 192	$ 0	$ 0
Community Based Process	$ 923,301	$ 610,054	$ 30,902	$ 0	$ 0
Environmental	$ 371,693	$ 768,116	$ 3,664	$ 0	$ 0
Other	$ 344,281	$ 2,539,372	$ 2,254	$ 0	$ 0
Section 1926 - Tobacco	$ 442,251	$ 0	$ 602,894	$ 0	$ 0
Column Total	**$5,213,644**	**$5,461,518**	**$663,784**	**$0**	**$0**

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 1,063,945	$ 3,600,214	$ 663,784	$	$
Universal Indirect	$ 2,318,973	$ 0	$	$	$
Selective	$ 1,830,726	$ 1,861,304	$	$	$
Indicated	$ 0	$ 0	$	$	$
Column Total	**$5,213,644**	**$5,461,518**	**$663,784**	**$0**	**$0**

Form11ab - Foot Notes

Other Federal: Safe & Drug Free Schools & Communities and Strategic Prevention Framework State Incentive Grant (SPF SIG)

State: Healthy Family Trust (State Tobacco Settlement funds) and General Revenue

Form 11c

Resource Development Planned Expenditure Checklist

State: Missouri

Did your State plan to fund resource development activities with FY 2009 funds?

(•) **Yes** ( ) **No**

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 300,000	$ 0	$ 300,000
Quality Assurance	$ 25,000	$ 0	$ 0	$ 25,000
Training (post-employment)	$ 42,500	$ 7,500	$ 0	$ 50,000
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 26,667	$ 361,026	$ 0	$ 387,693
Research and Evaluation	$ 50,000	$ 345,000	$ 0	$ 395,000
Information Systems	$ 0	$ 0	$ 0	$ 0
Column Total	**$144,167**	**$1,013,526**	**$0**	**$1,157,693**

Form 12

State: Missouri

TREATMENT CAPACITY MATRIX

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2009 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)	0	0
Free-standing Residential	16,840	11,830
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)	0	0
Short-term (up to 30 days)	21,462	17,164
Long-term (over 30 days)	0	0
Ambulatory (Outpatient)		
Outpatient	51,562	42,560
Intensive Outpatient	27,992	22,746
Detoxification	0	0
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	760	678

State: Missouri

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2009 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐ Competitive grants	Percent of Expense: %
☑ Competitive contracts	Percent of Expense: 98 %
☑ Non-competitive grants	Percent of Expense: 2 %
☐ Non-competitive contracts	Percent of Expense: %
☐ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $ Type of slot:
Rate: $ Type of slot:
Rate: $ Type of slot:

☑ Price per unit of service

Percent of Clients Served: 100 %
Percent of Expenditures: 100 %

Unit: quarter hour Rate: $ 11.67
Unit: daily Rate: $ 6.17

Unit: hourly

Rate: $ 10.65

☐ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $
Rate: $
Rate: $

Diagnostic Group:
Diagnostic Group:
Diagnostic Group:

State: Missouri

Program Performance Monitoring

- [x] On-site inspections

  Frequency for treatment: ANNUALLY

  Frequency for prevention: ANNUALLY

- [x] Activity Reports

  Frequency for treatment: MONTHLY

  Frequency for prevention: MONTHLY

- [x] Management Information System

- [x] Patient/participant data reporting system

  Frequency for treatment: MONTHLY

  Frequency for prevention: MONTHLY

- [x] Performance Contracts

- [x] Cost reports

- [x] Independent Peer Review

- [x] Licensure standards - programs and facilities

  Frequency for treatment: EVERY TWO YEARS

  Frequency for prevention: EVERY TWO YEARS

- [x] Licensure standards - personnel

  Frequency for treatment: EVERY TWO YEARS

  Frequency for prevention: EVERY TWO YEARS

Other:

- [ ] Specify:

- Foot Notes

In Missouri, monitoring for licensure standards for both programs and personnel for treatment and prevention occur every three years. The SAPT Block Grant instructions and software do not allow for this selection so the closest appropriate selection was made, "every two years".

Form T1

State: Missouri

Form T1 was pre-populated with the following Data Source: Discharges in CY 2007

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**4,071**	**3,509**
Total number of clients with non-missing values on employment status [denominator]	**14,506**	**14,506**
Percent of clients employed (full-time and part-time) or student	**28.1%**	**24.2%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**16,673**
Number of CY 2007 discharges submitted:	**15,300**
Number of CY 2007 discharges linked to an admission:	**15,021**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**14,846**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**14,506**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment status [denominator]		
Percent of clients employed (full-time and part-time) or student		

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**0**
Number of CY 2007 discharges submitted:	**0**

Number of CY 2007 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**4,455**	**4,433**
Total number of clients with non-missing values on employment status [denominator]	**11,594**	**11,594**
Percent of clients employed (full-time and part-time) or student	**38.4%**	**38.2%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**18,359**
Number of CY 2007 discharges submitted:	**13,363**
Number of CY 2007 discharges linked to an admission:	**12,468**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,024**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**11,594**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**6,119**	**6,680**
Total number of clients with non-missing values on employment status [denominator]	**11,565**	**11,565**
Percent of clients employed (full-time and part-time) or student	**52.9%**	**57.8%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**17,819**

Number of CY 2007 discharges submitted:	**13,547**
Number of CY 2007 discharges linked to an admission:	**12,801**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,346**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**11,565**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. As the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T2

State: Missouri

Form T2 was pre-populated with the following Data Source: Discharges in CY 2007

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with stable housing [numerator]	**9,483**	**9,710**
Total number of clients with non-missing values on living arrangements [denominator]	**10,410**	**10,410**
Percent of clients with stable housing	**91.1%**	**93.3%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**16,673**
Number of CY 2007 discharges submitted:	**15,300**
Number of CY 2007 discharges linked to an admission:	**15,021**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**14,846**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**10,410**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**0**
Number of CY 2007 discharges submitted:	**0**

Number of CY 2007 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with stable housing [numerator]	**7,761**	**7,813**
Total number of clients with non-missing values on living arrangements [denominator]	**8,155**	**8,155**
Percent of clients with stable housing	**95.2%**	**95.8%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**18,359**
Number of CY 2007 discharges submitted:	**13,363**
Number of CY 2007 discharges linked to an admission:	**12,468**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,024**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**8,155**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with stable housing [numerator]	**8,714**	**8,724**
Total number of clients with non-missing values on living arrangements [denominator]	**8,830**	**8,830**
Percent of clients with stable housing	**98.7%**	**98.8%**

Notes (for this level of care):	

Number of CY 2007 admissions submitted:	**17,819**
Number of CY 2007 discharges submitted:	**13,547**
Number of CY 2007 discharges linked to an admission:	**12,801**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,346**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**8,830**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. Also, as the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T3

State: Missouri

Form T3 was pre-populated with the following Data Source: Discharges in CY 2007

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with no arrests [numerator]	**9,564**	**10,294**
Total number of clients with non-missing values on arrests [denominator]	**11,292**	**11,292**
Percent of clients with no arrests	**84.7%**	**91.2%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**16,673**
Number of CY 2007 discharges submitted:	**15,300**
Number of CY 2007 discharges linked to an admission:	**15,021**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**14,983**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**11,292**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**0**
Number of CY 2007 discharges submitted:	**0**

Number of CY 2007 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with no arrests [numerator]	**8,011**	**8,263**
Total number of clients with non-missing values on arrests [denominator]	**9,097**	**9,097**
Percent of clients with no arrests	**88.1%**	**90.8%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**18,359**
Number of CY 2007 discharges submitted:	**13,363**
Number of CY 2007 discharges linked to an admission:	**12,468**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,356**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**9,097**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients with no arrests [numerator]	**8,881**	**8,935**
Total number of clients with non-missing values on arrests [denominator]	**9,514**	**9,514**
Percent of clients with no arrests	**93.3%**	**93.9%**

Notes (for this level of care):	

Number of CY 2007 admissions submitted:	**17,819**
Number of CY 2007 discharges submitted:	**13,547**
Number of CY 2007 discharges linked to an admission:	**12,801**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,773**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**9,514**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. Also, as the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T4

State: Missouri

Form T4 was pre-populated with the following Data Source: Discharges in CY 2007

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]	**6,544**	**7,964**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**10,786**	**10,786**
Percent of clients abstinent from alcohol	**60.7%**	**73.8%**
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**1,526**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,242**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**36.0%**
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**6,438**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,544**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**98.4%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**16,673**
Number of CY 2007 discharges submitted:	**15,300**
Number of CY 2007 discharges linked to an admission:	**15,021**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**14,983**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**10,786**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one		

substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**0**
Number of CY 2007 discharges submitted:	**0**
Number of CY 2007 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]	**6,265**	**6,670**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**8,264**	**8,264**
Percent of clients abstinent from alcohol	**75.8%**	**80.7%**

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**590**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**1,999**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**29.5%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		6,080
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,265	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		97.0%

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	18,359
Number of CY 2007 discharges submitted:	13,363
Number of CY 2007 discharges linked to an admission:	12,468
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,356
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	8,264
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]	6,881	7,680
All clients with non-missing values on at least one substance/frequency of use [denominator]	9,124	9,124
Percent of clients abstinent from alcohol	75.4%	84.2%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		971
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,243	

Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**43.3%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**6,709**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,881**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**97.5%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**17,819**
Number of CY 2007 discharges submitted:	**13,547**
Number of CY 2007 discharges linked to an admission:	**12,801**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,773**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**9,124**
Source: SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. Also, as the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T5

State: Missouri

Form T5 was pre-populated with the following Data Source: Discharges in CY 2007

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**3,897**	**5,970**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**10,786**	**10,786**
Percent of clients abstinent from drugs	**36.1%**	**55.3%**
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**2,228**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,889**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**32.3%**
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**3,742**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,897**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**96.0%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**16,673**
Number of CY 2007 discharges submitted:	**15,300**
Number of CY 2007 discharges linked to an admission:	**15,021**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**14,983**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**10,786**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		

Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**0**
Number of CY 2007 discharges submitted:	**0**
Number of CY 2007 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**4,629**	**5,274**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**8,264**	**8,264**
Percent of clients abstinent from drugs	**56.0%**	**63.8%**

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**951**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,635**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**26.2%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**4,323**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,629**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**93.4%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**18,359**
Number of CY 2007 discharges submitted:	**13,363**
Number of CY 2007 discharges linked to an admission:	**12,468**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,356**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**8,264**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**7,341**	**7,720**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**9,124**	**9,124**
Percent of clients abstinent from drugs	**80.5%**	**84.6%**

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**597**
Number of clients using drugs at admission (records with at least one substance/frequency of		

use at admission and discharge [denominator]	**1,783**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**33.5%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**7,123**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**7,341**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**97.0%**

Notes (for this level of care):	
Number of CY 2007 admissions submitted:	**17,819**
Number of CY 2007 discharges submitted:	**13,547**
Number of CY 2007 discharges linked to an admission:	**12,801**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,773**
Number of CY 2007 linked discharges eligible for this calculation (non-missing values):	**9,124**
Source:SAMHSA/OAS TEDS CY 2007 admissions file and CY 2007 linked discharge file [Records received through 5/27/2008]	

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. Also, as the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T6

State: Missouri

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL	To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.
MEASURE	The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.
DEFINITIONS	Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available	From: 1/1/2007	To: 12/31/2007

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	5142	7527
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	41069	41069
Percent of clients participating in social support activities	12.52%	18.33%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Since October 2006, participation in self-help activities is collected in the State's information system at admission, at type of service changes, and at discharge. Prior to October 2006, participation in self-help activities was only collected at discharge. Data is required for all clinical treatment programs.

DATA SOURCE	**What is the source of data for table T6? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source

	☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T6? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T6? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ____ ☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission

	☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

- Foot Notes

In October 2006, the State implemented a new information system. System bugs did impact the State's collection and reporting of TEDS data. Also, as the result of additional level-of-treatment information in the new system, the State changed the way it crosswalked modalities to TEDS type of service. This limits the comparability of NOMS by modality to past years' data.

Form T7

State: Missouri

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2007 To: 12/31/2007

Length of Stay			
Level of Care	**Average**	**Median**	**Standard Deviation**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	2	2	3
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	22	20	15
5. Long-term (over 30 days)			
Ambulatory (Outpatient)			
6. Outpatient	75	65	49
7. Intensive Outpatient	62	55	48
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy			

- Foot Notes

The State has discovered a coding error impacting TEDS submission of Opioid records. Error has been corrected and 2008 records will be re-submitted - deadline for 2007 records is past.

Missouri
INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.
Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.
If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?
What actions does the State take as a result of analyzing performance management data?
Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?
If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency. Do workforce development plans address NOMs implementation and performance-based management practices? Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), as the Single State Authority (SSA) has used data-driven decisions based on a limited number of performance measures in the past. Effective October 1, 2006 the SSA implemented a new web-based information system Customer Information Management, Outcomes, and Reporting System (CIMOR). CIMOR replaces multiple legacy systems – integrating billing and client tracking. CIMOR has been designed to capture the data elements needed for Treatment Episode Dataset / National Outcomes Measures (TEDS/NOMS) reporting. CIMOR screens collect this data at admission, at level changes, and at discharge. Design flaws in the CIMOR data model, however, have impacted the data integrity of the State's outcome data. The implemented data model was not designed to store the data at admission and level changes. From October 2006 to July 2007, data collected at level changes overwrote admission data. The fix implemented in July 2007 addressed the overwriting bug but created additional problems impacting data retrieval. Additional enhancement requests failed to adequately alleviate the difficulties. In the fall of 2007, ADA Research staff consulted with Information Technology Services and Development (ITSD) staff. ADA submitted a request to the CIMOR steering committee to have the data tables re-designed. The request was approved. Re-design work began in Spring 2008 but was slowed by ITSD staffing changes. To date, the CIMOR ADA tables have not been fixed.

In 2007, ADA sought State Outcomes Measures (SOMMS) Information Technology technical assistance. Working with RTI International and the National Data Infrastructure Improvement Consortium (NDIIC), the State identified needs in the following areas:

- System analysis of CIMOR business rules.
- Evaluate the current and proposed design of the CIMOR ADA data model impacting TEDS/NOMS data.
- Develop a TEDS/NOMS data view for ADA research staff to use to monitor outcomes.
- Analyze reporting needs and develop requirements for reporting. Provide assistance for developing new reports for improving performance management.

NDIIC was awarded the contract to design and develop reports to address data quality and performance monitoring. An RFP has been opened to bids to address the other components.

Problems with CIMOR have significantly delayed the State's implementation of performance management reporting. The State is proceeding with process measure reporting based on administrative data. In Spring 2008, ADA staff from the treatment, fiscal, research, and Substance Abuse Traffic Offender's Program (SATOP) units developed a list of needed process measures. Measures were identified for across programs (Core) as well as specific to programs 1) Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Women's, 2) CSTAR Adolescent, 3) CSTAR General Population, 4) Primary Recovery, 5) Compulsive Gambling, and 6) SATOP. In August 2008, ADA research staff attended the performance management track at the

State Systems Development Program (SSDP VIII) and received additional information on measures developed by other States and groups. ADA is in the process of reviewing this information in conjunction with the State's list of identified measures. ADA research will be presenting draft report specifications to the ADA Policy Advisory and Development (PAD) group in September/October 2008 and then subsequently to the provider directors. ADA plans to have process measure reporting in operation by the end of 2007. ADA will be examining the entire reporting process in addition to report development. ADA will be considering report functionality, mode of distribution, and training support for report users.

ADA's primary recovery program, as part of the Access to Recovery (ATR) II grant, has outcome data based on the six month post-admission follow-up Government Performance and Results Act (GPRA) tool. Admissions under ATR II began December 17, 2007 and collection of GPRA follow-ups began May 17, 2008. GPRA follow-up rates are monitored by provider on a weekly basis with a report submitted to the State's ATR II staff. ADA plans to generate quarterly outcomes reports for ATR II providers in October 2008.

To date ADA has not set benchmarks but is interested in implementing provider incentives. This is dependent, however, on the development of a provider reporting system. ADA expects providers to improve data quality and program performance but recognizes the need for reporting tools to support this process.

Missouri has not developed evidence-based practices (EBP's) or programs however ADA incorporated EBP's in all treatment and prevention programs.

At this time, ADA does not have a regular training program for provider staff or a workforce development plan but is in the discussion phase of both.

The Division of ADA requires providers to supply information about the intensity and numbers of services provided to consumers via the CIMOR system.

Other reports are compiled on an annual basis including: Status Report on Missouri's Alcohol and Drug Abuse Problems; School-based Prevention Intervention and Resources Initiative (SPIRIT); Compulsive Gambling; Block Grant, and Synar. The Missouri Student Survey is produced in even-numbered years and monitors the risk behaviors of middle and high school students in public schools in the state. All of these are available on line at http://www.dmh.missouri.gov/ada/adaindex.htm or http://www.missouriprevention.org/. ADA responds to frequent data requests from legislators, providers, media, and the public.

Missouri
Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Form P1

State: Missouri

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2006	31.50	
		Ages 18+ - FFY 2006	51.70	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12–17 - FFY 2006	14.20	
		Ages 18+ - FFY 2006	33.70	
3. 30-day Use of Other Tobacco Product	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12–17 - FFY 2006	8.70	
		Ages 18+ - FFY 2006	11.80	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2006	6.70	
		Ages 18+ - FFY 2006	5.60	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2006	5.40	
		Ages 18+ - FFY 2006	3.60	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

State: Missouri

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Cigarette	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	95.40	
		Ages 18+ - FFY 2006	93.20	
1. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	79	
		Ages 18+ - FFY 2006	79.50	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	85	
		Ages 18+ - FFY 2006	75.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P3

State: Missouri

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2006	13.10	
		Ages 18+ - FFY 2006	17.20	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2006	12.40	
		Ages 18+ - FFY 2006	15.20	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2006	13.20	
		Ages 18+ - FFY 2006	18.50	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2006	13.30	
		Ages 18+ - FFY 2006	17.70	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2006	12.90	
		Ages 18+ - FFY 2006	20.90	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

State: Missouri

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	88	
2. Perception of Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2006	82.70	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	83.50	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	83	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	88.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P5

State: Missouri

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2006	24.20	
		Ages 18+ - FFY 2006	46.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P7

State: Missouri

NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2006	94	

((s)) Suppressed due to insufficient or non-comparable data

Form P8

State: Missouri

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2006	45.60	

((s)) Suppressed due to insufficient or non-comparable data

Form P9

State: Missouri

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2006	221.60	

((s)) Suppressed due to insufficient or non-comparable data

Form P10

State: Missouri

NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2006	56.90	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2006	((s))	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

State: Missouri

NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2006	93.60	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

State: Missouri

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Missouri used the MDS and manual process data collection systems.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Missouri collects and records a participant's race through the MDS system and manual collection process.

Category	Description	Total Served
A. Age	1. 0-4	584
	2. 5-11	29277
	3. 12-14	23457
	4. 15-17	19611
	5. 18-20	6127
	6. 21-24	2513
	7.25-44	20097
	8. 45-64	11695
	9. 65 And Over	910
	10. Age Not Known	69284
B. Gender	Male	23182
	Female	33790
	Gender Unknown	126583
	White	66165

C. Race	Black or African American	49774
	Native Hawaiian/Other Pacific Islander	51
	Asian	372
	American indian/Alaska Native	320
D. Ethnicity	Hispanic or Latino	66863
	Not Hispanic or Latino	4553

- Foot Notes

Not all programs reported ethnicity. The total for category D: Ethnicity category for "Not Hispanic" includes 69,284 where no ethnicity was reported.

Form P12B

State: Missouri

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	19335129
B. Gender	Male	
	Female	
	Gender Unknown	19335129
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	

	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	19335129
D. Ethnicity	Hispanic or Latino	118592
	Not Hispanic or Latino	5595211

- Foot Notes

Ethnicity is based on 2000 census for Missouri.

Form P13

State: Missouri

Number of Persons Served by Type of Intervention

Form P14

State: Missouri

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Missouri uses the Strategic Prevention Framework process to implement the three guidelines. The process includes: assessment of the community needs and readiness; capacity building to mobilize and address the needs of the community; development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs; implementation of the prevention plan; and, evaluation of the results to achieve sustainability and cultural competency. Missouri identifies appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Southwest Center for Application of Prevention Technology, and SAMHSA's Center for Substance Abuse Prevention. The Division of Alcohol and Drug Abuse ultimately determines whether or not a chosen intervention falls under the third definition.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Missouri utilized a combination of the Minimum Data Set (MDS) and manual collection.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	13	7	20	14	1	35
2. Total number of Programs and Strategies Funded	13	7	20	14	1	35
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Form P15

State: Missouri

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	13	2	16 %
2. Universal Indirect Programs and Strategies	7	7	100 %
3. Subtotal Universal Programs	20	9	45.00%
4. Selective Programs and Strategies	14	5	36 %
5. Indicated Programs and Strategies	1	1	100 %
6. Total All Programs	35	15	42.86%

- Foot Notes

For Universal Direct Programs, 84% fall below the 25th Percentile cost per participant. For Selective Programs, 64% fall below the 25th Percentile cost per participant. For Total Programs, 57% fall below the 25th Percentile cost per participant.

Missouri
Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Prevention Attachments A, B, and C (optional)

State: Missouri

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

State: Missouri

Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet

Subrecipient Name:_____

Date Form Completed:_____

Name of Contact Person:_____

Phone:_____ **E-mail Address:**_____

Table 1: Progam Detail

1	2	3	4	5	6
Program Name	**Number of Participants**	**Number of Program Hours Received**	**Total Cost of the Program**	**Average Cost Per Participant (Col 4/Col 2)**	**Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)**
Universal Direct Programs					**Universal Direct: $58.01–$693.98**
1.					
2.					
3.					
4.					
Universal Indirect Programs					**Universal Indirect $1.05–$82.26**
1.					
2.					
3.					
4.					
Selective Programs					**Selective $151.88–$6,409.29**
1.					
2.					
3.					
4.					
Indicated Programs					**Indicated $510.47–$4,888.44**
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	**Number of Programs**	**Number of Programs Falling Within Cost Bands**
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- ***Universal.*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- ***Universal Direct.*** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).

- ***Universal Indirect***. Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

- ***Selective.*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- ***Indicated.*** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participant s served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a "1" in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded "1" in Table 1, column 5).

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Missouri
Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

Missouri
Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)
No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.